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ABSTRACT
The objectives for this advanced study institute were to define learning disabilities so that the definition would be useful for national application; to define interrelated problems; and to establish the extent training centers and university training programs could be augmented and oriented to meet the urgent demands of the nation in these areas of special education. Speeches and discussions delineate changes in outlooks for professional training; estimate the incidence of learning disability and the problem of interrelated areas. The report of the proceedings program is enriched by the concluding discussions. (ON)

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Transcript of Proceedings

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LEARNING DISABILITIES AND INTERRELATED HANDICAPS

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Parkes Hall
Northwestern University
Evanston, Illinois

Tuesday, August 8, 1967

The Conference was convened at 9:05 a.m., Dr. Helmer R. Myklebust, Director, Institute for Language Disorders, Northwestern University, Chairman, presiding.

PRESENT:

DR. HELMER R. MYKLEBUST (Chairman)
Director, Institute for Language Disorders,
Northwestern University

DR. SAMUEL A. KIRK, Director
Institute for Research on Exceptional Children
University of Illinois

DR. CORRINE E. KASS, Coordinator
Interrelated Areas and Learning Disorders
Bureau of Handicapped Children,
Department of Health, Education and Welfare
Office of Education, Washington, D.C.

DR. ERWIN O. SMIGEL, Head, Department of Sociology
Graduate School of Arts and Science
New York University

DR. JAMES H. McBURNEY, Dean,
School of Speech
Northwestern University

PRESENT (Continued):

DR. SAMUEL C. ASHCROFT, Chairman
Department of Special Education
George Peabody College

DR. FRANCIS X. BLAIR, Director of Professional Training,
School for Research on Language Disorders
University of Wisconsin-Milwaukee

DR. JAMES C. CHALFANT,
Assistant Professor of Special Education
University of Illinois

DR. EVELYN DENO, Professor
Educational Psychology
Department of Special Education
University of Minnesota

DR. LOUIS A. FLIEGLER, Chairman
Department of Special Education
Kent State University

DR. PHILIP H. HATLEN, Associate Professor
Department of Special Education
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Education of the Mentally Retarded
Division of Training Programs
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DR. FRANK M. HEWETT, Chairman
Area of Special Education
The Neuropsychiatric Institute
UCLA Center for the Health Sciences

DR. ROBERT H. RIDGWAY, Associate Dean
School of Education
University of Kansas

DR. HARRIE M. SELZNICK, Director
Division of Special Education
Baltimore City Public Schools

MISS JOSEPHINE TAYLOR
Director of Education Services
New Jersey Commission for the Blind

DR. WILLIAM G. WOLFE, Chairman
Department of Special Education
University of Texas

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PROCEEDINGS

DR. MYKLEBUST: It is my pleasure to call you to order this morning. I trust you all had a little rest last night.

We will get on with the first part of our program. am very happy that Dean McBurney, Dean, School of Speech, cou come over for just a few minutes to meet you people and to gi you a few remarks.

DEAN McBURNEY: Thanks, Mike.

I am scheduled to bid you welcome. I imagine this has already been accomplished since I understand you met last night.

Be that as it may, we are delighted to have you wit us. I am sure that Dr. Myklebust and his associates will be very gracious and competent hosts.

They have developed a program in learning disabilit here with us which I think has accomplished a number of thing for the University.

I think it has -- and I trust Mike will agree with this -- served to integrate and unify many things that we have been doing over the years in very helpful ways, and I think too it has provided a conceptual framework or platform for projecting new areas of study, new research endeavors.

Now, I understand that one of the primary purposes of your meeting here today and tomorrow is to define some of these concepts with which we and you have been dealing. To me, this should be a very useful undertaking, and I wish you all success in this enterprise.

Now, ladies and gentlemen, I have a class waiting me -- I hope -- so, if you will excuse me, I will turn you over to Dr. Myklebust, and I am sure you will be in very goo hands.

Good luck with your meeting. Thank you.

DR. MYKLEBUST: Now, I know you are a little concerned about this room being warm yet this morning.

(Remarks off the record concerning arrangements.)

DR. MYKLEBUST: Unless you have questions or commen this morning, if everybody is all set to go on, then it is my pleasure to introduce Dr. Smigel.

We are very pleased Erin Smigel would take the time to come out here to be with us. Now, his field is sociology. He is head of the department at NYU.

As I am sure most of you know, he has been interest for some time in professionalism -- that is, who is the professional and how the world of professional training expecial is changing.

Now, it is for this reason and other reasons that w very much wanted him here this morning.

Dr. Smigel, you can remain seated if you care to, whichever you prefer, and we are happy for you to go ahead, please.

DR. SMIGEL: Last night as I was thinking about what I would say this morning, I decided that I knew you well enoug that I didn't have to tell a standard bad joke. But it turned out the bad joke I decided not to tell came to be true -- and that is that the preliminary notes that I wrote last night I lost.

And I was going to say to you, "On the way to the forum I lost my notes." (Laughter) And I thought that was a bad joke. And it turned out it was true.

But what I was going to say was that I was very impressed with the work you are doing. It seems like you are al on great adventures.

In this group they don't seem to be as separate as they did in a conference I attended in Maryland, which some of you also attended, but it does bring up the problem I want to talk about today.

That is, if you in this group and in others like you want to form professional association and want to be considere professionals in terms of the kind of work you are doing, not in terms of your job as a teacher or in terms of some other standard, then what does it mean to be a professional?

Suddenly there has been a lot of interest in professions, and there has been an interest in occupations. The interest in occupations seems to have started during the depression when work became important because of the lack of i

Some people decided to think what were they going to do, how were they going to get out of it, and this brought it to sort of public attention.

Then, during the War, the interest increased, becaus the Army was classifying people by occupations, and some were staying out, and some were getting better jobs for being in.

And so we have this tremendous increase in interest in professions, in occupations.

However, during these years the occupations have bee in a process of change. What was a physician 30 years ago is not a physician today. Certainly physics 30 years ago is not physics today. I think we can go down the line of most major professions and find that they have changed radically.

What I would like to do today is discuss some of th difficulties in determining what a profession is. It seems t be a simple word, but it really isn't a simple word. There a a number of definitions. There are lay definitions which are incorrect or irrelevant as far as we are concerned.

One such definition is that the professions are synonymous with occupations. In other words, everybody says "in my profession." The cab-driver says "In my profession I have to do such and such."

Then we have professional versus amateur -- so the professional baseball team versus the college baseball team.

And we don't mean "professional" that way, but these words are often used that way. And, unfortunately, they mix us up.

Then we have the use of the word "professional" as invidious and derogatory, and they talked about the leader of the band saying, "Now, Professor, one, two." And this, of course, not what we mean.

However, even though these definitions are not the ones we are going to use, they become important because if people use them and see them a certain way and see professions in a certain way and then react to the word in a certain way, it has significance for us all along the line.

We don't really know very much about what degree of uniformity there is in lay people's concept of what a profession is.

I did have a student who was doing a study of this, and I saw the results, but I haven't seen the final material. What he did was to take a small town and give a series of sentences that equal the definition of profession. He gave it to both professional people and lay people to see if they had different concepts of professions.

He gave more than a series of what is a profession. He also gave occupations, mixing it in, so they had to pick out what factors made up a profession.

Well, in addition to the lay conceptions, we have conceptions of the professions current among the established professions. In other words, what do professionals think professionals are?

Now, this becomes important to know something about, because it has to do with referrals, and it also has to do with recruitment and status. In other words, if a psychiatrist thinks that something is a profession, he may refer work to that job which he considers a profession. But if he has a low opinion of that occupation, he doesn't refer work.

There have been a lot of studies in terms of lay people about what they know about different occupations, one study by Merton and Hatt. Merton you may have heard of. He was head of the department at Columbia, and he has worked in this field a long time.

Merton found that there were only three professions that everybody except 1 per cent of the country knew something about -- whether it was eaxct or not. Those were medicine, law, and the ministry.

After that, as you went down the list, they knew less and less, until it became very vague, especially in the physical sciences.

Sociology, for example, received a fairly high rating in a list of 90 occupations in terms of status. When they asked the people what they thought sociology was, they really didn't know. So they were voting on whatever their image was in terms of a status.

Then, it becomes important to have an identity both for lay people and for professional people.

In a study in Louisville some time ago they asked physicians, lawyers, ministers, school-teachers under what circumstances, if at all, would they send people to a psychiatrist. And physicians, even though psychiatrists are physicians, were the least likely at that point in history to send patients to psychiatrists.

Therefore, if the psychiatrist really wanted referrals -- which they don't need anymore -- if they really wanted the referral system -- and where the best referral system was from other physicians -- they'd have to do something about changing their image.

Another concept is the concept of administrators or legislators. This becomes very important because there are a lot of jobs that come from the Federal Government, and these jobs are labeled. And if they are labeled sociology, the sociologist gets it. If they are labeled statistics, for example, sociology may be the statistician, and it may be something else.

And in new occupations, new professions, one of the things that I suppose a new profession needs is recognition by the Federal Government for grants, for monies. Who do you apply to? How do you know what to apply to? How do you know what jobs exist if it doesn't have your title?

So the American Sociological Society moved down to Washington, where they already found political scientists and I think the psychologists and I don't know how many other disciplines had moved.

So I think a lot of professional groups are in Washington to try to influence the Government in determining whethe they are a professional, whether their names should be listed in the list of jobs.

All right. Now, then, we come to the researchers' and sociologists' picture of "profession." And there are a number of different definitions.

In fact, all cultures name and classify occupations, and these classifications imply prestige, high, low, et cetera.

In the English-speaking world the term "profession" is now used for certain occupations which enjoy a great deal of prestige and which give some esoteric services often based on science.

So, first, we have the idea that all professions are occupations but all occupations are not professions.

Now, occupations which are professions apply some esoteric scale plus the motto that "the taker believe in us," as against what business people say -- "let the buyer beware."

In other words, the professional man has to have th confidence of his client. The businessman probably should. But we don't trust him as much as we trust our physician.

Even if we are doubtful about the physician, when we go to a physician, we may go to another one, but we don't go to a series of them usually.

If we buy a used car, after ruining our shoes incorrectly kicking the wheel, we keep going to one place after another looking for that used car -- and always afraid that we are getting cheated.

So let the buyer beware is still true in business, though less so. And let the taker believe in us is still true in the professions, but maybe less so.

One of the places that it is still true is among the elite. An elite lawyer will not let his client tell him what to do. He will just say, "If you don't want me, I'm not going to play."

It turns out from my sources in medicine that the solo practitioner feels all sorts of pressure from the patient: "Okay, Doc, will you give me a shot." Pennicillin he means. You have to use "shot" now carefully. "Will you give me a shot?" And they feel badly if they don't get this shot.

Or, "Write out an excuse for my son, even though he wasn't sick" -- or for the insurance companies. And all sorts of things that they don't seem to want to do but feel they have to do to keep their clients.

Elites in the profession won't do that.

All right. Now, another thing that happens to us is that we are still using the 19th century model of professions. That is, we still use medicine and law as our models. We still use the solo practitioner as the model. We still use what we used to call the free professions.

That is, a profession is conceived as an esoteric art practiced by a closed group of people, each by himself, eac having relations to a number of separate clients, and each collecting his own fees.

This was the 19th century image, and this is what some of the canons of ethics are still based on, even though we live in an entirely different world now.

You can't practice by yourself anymore. At least you can't practice properly by yourself anymore.

So that lawyers in New York City who claim to be solo lawyers have built a network, an informal network, of relationships with other solo lawyers who start getting expertise in various fields. They are not as specialized as the law firms that I studied, and I will talk to you about that in a second, because these become the model of what the new professions are becoming. But they do become specialized.

Now, in Bloomington, Indiana, where I lived for eight years and did a little study of lawyers there -- lawyers happen to be my field so this will be where my examples mostly come from -- they did have 28 lawyers there. Most of them were solo, but most of them were doing very simple kinds of work.

A lot of them were bill-collecting, and this is best done by yourself with a "strong arm" man.

A lot of them were doing some minor criminal work, and only two or three had some sort of firm.

Now, whether they had this network yet or not I don' know, but eventually they will. Since there is such a prolifeation of knowledge and since this is growing at such a fast rate in all areas in this country, all areas that we think about in terms of the profession, you can't know everything. You just can't know everything anymore.

In sociology, for example, you go to an industrial sociologist with a question on the family, and he says, "That' not my field." It's hard enough for him now, with all the books on sociology and journals, to keep up with industrial sociology.

All right. So, now, this is part of what is happening. You can't practice anymore by yourself.

And the lawyers in Wall Street -- and by "Wall Street" I mean LaSalle Street here, any business street -- th lawyers in Wall Street don't practice by themselves. And part of their strength lies in the fact that they specialize.

In my study, the largest firm had 160, which is the number I have here, but by the time I looked it up again it was 167 lawyers. Now, imagine 167 lawyers practicing together. This is a new world.

Underneath them there are 200 other people, clerks, filers, typers, investigators, and so on. All under that. There are 400 people sitting up in these buildings on LaSalle Street.

The largest one here when I was here -- and I studi four firms in Chicago -- had 100 lawyers in it. And in Houston there are three or four of them now with this number.

So it is so all over the country. San Francisco ma have five like that, or more now.

I wrote to each big city over 100,000 and asked the the numbers of their firms.

All right. Now, I studied 20 of these large firms in New York, and I wanted to see what happens to professional people when they have to work together, when they have to wor as a team.

Because one of the fears that people have, that professional people have, is that if they work as a team they lo part of their autonomy, part of their independence, which is what professional people want.

So, how can you have both? How can you work together and still be autonomous? How can you be a team and be independent? How can you be professional in a real sense of the word, in a major sense of the word?

Or in medicine, if we want to get away from the law for a minute, there isn't a doctor in a big city who can prac without a hospital. You just can't practice without a hospital. Some may because they can't get in, but you really can't practice medicine anymore without a hospital, without the laboratories, without all the other occupations, semi-professional and professional occupations, that go with medicine today.

Medicine is no longer the doctor and serfs underneath him, though the doctor may still think that is what it is. Medicine is not practiced that way.

And this is going to increase -- that is, the dependence of the doctor on other practitioners.

Now, the present model of the professions isn't valid anymore. And what is happening to the professions has already happened in industry.

In industry, with automation, we start breaking jobs down into smaller and smaller items. And the great invention of Henry Ford is that he put machine and man together in some sort of working order. That was his social invention. He put them together -- these small jobs, smaller and smaller jobs, that men had to do with a machine.

And what that means is that we have to think of specialization in a different way. We used to think of specialization that a physician was a specialist as against other people. Now a physician is not a specialist as against other people -- though he still is. He himself has specialized.

But a shoemaker used to do the whole shoe. Now he does the last. Someone else does the heel, and someone else does something else. He doesn't do the whole shoe anymore except in esoteric places in the Village and in Italy where people want this kind of shoe.

So the meaning of specialization has changed. Specialization means now smaller and smaller jobs which require an integrator, which require people to put them together.

So if you go on the assembly line at Mayo Clinic, each of the specialists now in the professions sees you, and at the end of the line some guy has to put you together again. And we call him what? The internist.

And all the management schools in the country are trying to form groups of people who will be the "internists" for management. And these people are trying to become professional people.

So we need integrators.

Now, let's go back to that other question, and that was the question of my book: What happens to professional people in bureaucratic situations? What happens to professional people in teams? Do they become what White and Mills and Reisman thought of as the organization man? Do they become so conforming that they really don't give us the kind of service that we need?

If you are a patient and you are sick, very sick, you want a man who can think freely, who doesn't have to follow certain kinds of rules. Because you never would have had to go to the specialist if you could have gotten cured before that by a routine person. You want someone who can think out a problem and think of it in a different way and is free enough to be able to help you.

So we have to find out: Is it possible for a person to have independence and autonomy, two of the very important words in a profession. Independence and autonomy.

Now, educators are accustomed to that. And in the best schools we have that. So it may be possible thatcertain organizations can be set up so that for certain things, professional aspects of our lives, we can have independence and autonomy.

All right. We can't have it in room assignments. But we don't really need it in room assignments.

We can have it in terms of what shall we teach, what kind of research can we do, and the better the school, the more freedom you have.

So there are organizations set up to give us our independence.

I will forget about these notes since I am not following them anyway.

In my study what I found was that the organization, in fact the entire profession, of élites -- the élites -- did have this independence and autonomy.

They were conforming in terms of dress and where they lived. I took the entire sample of partners for three law firms. If they lived in the city, if they didn't live in the suburbs, they all lived in one section of the city, nowhere else. Not one of them. So they were conforming in terms of that.

In terms of dress they certainly were conforming. They all wore the hat, the suit, the Brooks Brothers suit, the proper tie. And I think if you did not wear that there would be a wearing out process -- I mean a weeding out process -- wearing out too, but weeding out also.

Of course, it takes ten years to become a partner. By that time people know you, and by that time you know what is expected. But it really starts much earlier than that, since a lot of these people were born into a social class that expected them to dress this way anyway, so they may not have been conforming expediently. This may have been their way of life.

Half the people in my sample went through prep school in terms of the partners. Thirty-three per cent of them were in the social register. So you can see what kind of special homogeneous group I was studying.

Well, what I found was that, while they did dress in a conforming manner and while they did live where they were supposed to live socially, they didn't conform in what we

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usually call-- Well, they didn't expediently conform. That is, they didn't conform in terms of their work for the benefits of the job.

They conformed in what I call creative conformity. And that means that the situation demanded creativity. And if they were going to become partners, they had to be creative.

It all started with training, which is part of the definition of a profession. It started before the law school but probably in the law school too, especially for law review people.

Law review people are those especially bright people who have their own journal in which they decide whether the professors' articles are going to be published. They then are really arguing on a basis of equality, which is part of what the definition of "professional" implies. That is, it is a body of equals, even though it may not be true. It is a body of equals, and the law schools are training them to be a body of equals.

What happens with the case method is when you go into a law school that in the case method the professor says, "State the case." All right. And you state the case. And then what happens is that the law professor then tries to trap you and says, "Well, what can you use this case for?"

And you say, "Well, in such and such versus such and such and such this happened."

And then they argue back and forth. And this is something that those of us who are professors don't do enough of in other classrooms. But in the law they do this. In the law they force you to fight back.

And what these firms try to do is to force the clerk to fight back. And both of them agreed, the clerks and the partners agreed, that this was something that they had to do if they were going to stay. They had to argue, but they had to argue in a polite manner, in a conforming manner.

They couldn't say to the partner, "Listen, you don't know anything about this. That's really not your field." They had to say as one of them did say while I was in the room The partner came in. After we went through the social business, the partner had a brief the clerk had written, and he handed it back, and said, "I don't like such and such."

And the clerk said, "Well, the client wanted it, and it doesn't do any harm."

The partner said, "Okay."

Then he said, "Well, I sure don't like this."

And the clerk said, "Perhaps you haven't seen the latest opinion. May I get it for you?"

So he was still keeping the hierarchy, but he was telling him just as politely as if he had said it, "Look, you don't know what you're talking about."

The partner, however, who had been through the same thing, because most partners, except defeated Presidential candidates and some Cabinet Members, start from the beginning-- Not Stevenson and not Dewey or Davis or Willkie. They all have their names on the top of these firms, but they start at the top. And Nixon. None of these people start from the bottom. They started from the top.

And then they argued. And finally they wanted to break it off, but the clerk wanted to continue.

He said, "This is very important. May I see you this afternoon?"

The partner wanted to keep this on a professional basis and said, "Yes. What is a good time for you?"

The clerk said, "Is two o'clock all right?"

And then they met and kept going.

So this is the kind of thing that occurs in these law firms.

Now, my next question in my next study, and one that is much broader, is: What happens if you are a house counsellor. That is, if you are house counsel for General Electric? There are 200 or over of them.

Now, you are working for one client. We are going a little further now than I went. They are working for one client. And they are called the "kept lawyers" of industry. In Texas they are called the "stall bed lawyers," and so on.

In other words, the implications are that they are not professional people.

One of the ways of looking at that is that professional people have privilege, a concept of privilege. Not all professional people have that, but lawyers have that, physicians have that, and I assume some day that you people will want it or have it or will have to fight for it in the courts.

But somewhere along what people tell you should be privileged. And I don't know what the decision is yet for you.

But one of the problems here for the house counsel is that certain people said, "No, you're not the house counsel. You're really part of the corporation, and therefore you can't keep secrets about yourself."

They said, "No, we're lawyers. And even though we are working, we are separate."

And the question is for me whether there is enough force in the culture of lawyers to keep them independent. And it is something I call professional bureaucracy. It is a structure that is outside of bureaucracy but formed by professional people. It is their rules and their norms, which is part of what is a definition of "profession."

Now, another thing that is going to be most interesting for you, because I think it fits in to your heterogeneo society or group to the extent that you are organized, is that there is no such thing as a lawyer anymore. We used to say "lawyer," and I said that all but one per cent of the population knew something about lawyers. Well, it turns out there isn't such a thing as a lawyer, because lawyers are so different in terms of a continuum that they are like day and night.

A man named Carlin here at the University of Chicago wrote about the solo lawyer. His father happens to be in a large firm in Chicago, but he wrote about the solo lawyer.

They do absolutely different things than my lawyers. First of all, they come from different backgrounds. They were sons of immigrants, most of them. Secondly, they went to night schools, which are now disappearing. Third, they practice what is left over in the law, the criminal law, negligence cases, the bill-collecting, the divorce law, the kind of law that the people I studied wouldn't touch, would not touch.

They practice in different courts. They practice in the lower courts. They don't practice in the higher courts.

They go to the schools where they are not taught the same kind of independence, though a lot of them get it in a different way because they are scrambling for it. They have to stay around the courts picking up clients, whereas the people that I studied don't pick up clients. The young fellow comes in, and the clients are there. The clients have been there for 50 years. The clients can't leave. They hardly ever leave. The only way they leave is if there has been a merger and they have to decide between two law firms. They just don't leave.

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If you recall Auchincloss and his books about lawyers, he has one I think called "The Law of the Lions," where the client wanted to leave but the interrelationship was too great. Because one of the things the large law firm does is give you, the client, their lawyers, their graduates, you see. Only one out of 12 becomes a partner, and the others start going into the corporations. And so the relationship gets thick.

And what is the corporation anyway? The head of the corporation isn't the corporation. He is just one aspect of it.

So they have the neighborhood client. They have to bribe the police and the petty bureaucrats. They do the ambulance chasing. They sit around the courthouse and the bail shops and compete for clients.

With the other lawyers, 70 per cent of them came from Yale, Harvard, or Columbia Law Schools. They were at the top of their Ivy League colleges. They can get a job anywhere, especially if they were law review and had a personality. They were mostly Anglo-Saxon, though this is changing somewhat.

In one firm, 75 out of 100 associates were on the law review. I have never seen a brighter group of people in one organization in my life -- never. More Phi Beta Kappas than I am sure on most faculties were in these shops.

Now, it is true they get dull in a way, because they are getting so specialized. But the people who use them want them to be just the way they are, and they know how to work together. So what I am saying is, a lawyer doesn't mean a lawyer, and a physician doesn't mean a physician. The psychiatrist, the general practitioner, and the specialist all perceive things differently. All see things differently. And this may be an item of importance to you, because in this group -- not in this particular group, which is much more homogeneous than I think your wider association is -- it is so heterogeneous that you have to think of what you have in common.

Lawyers have something in common. They have a common education, which is not quite as common as they think, but it does have the basics which they have in common, and then they start spreading out.

So what we found for lawyers may be true for every occupation.

And as to the word "specialization," going back again from that of the specialization in industry, the specialization in medicine, specialization in your field becomes greater and greater.

Now, I sense that some of you don't like what is happening and are really fighting this. I also feel what is going to happen is that eventually there will be so much information that, whether you like it or not, you are going to have this problem of smaller and smaller specialization -- unless the machine comes in to help you as it came in to help industry.

In other words, what happened to the specialization in industry? The new automation is putting all those jobs that man had to do, the small jobs, together so that a lot of the jobs are becoming lost.

A student of mine had a project this year. I don't know the exact figures, but I will give you an impression. A student of mine went through the Dictionary of Occupational Titles to see how many jobs disappeared. Because we know how many jobs were added. But he wanted to see how many jobs and what jobs disappeared.

Well, it was over 4,000 jobs that disappeared in the ten-year or 20-year period that he took. And most of them had to do with where the machines came in.

Now, if the machines come in for medicine, a lot of the work that physicians have to do in even diagnosis will be done by machines. And in law the basic "shepherdizing" of the case, which means what are the precedents, will eventually be done by machine. So we won't need the clerk in the same capacity, and this may change things again.

And it may give you more time to do other things and be broader. So the machine may be the hope of being broader.

Now, what machines are going to come to help you I don't know. But in the meantime it seems to me, from my own experience in sociology, that what is happening is that we are becoming narrower and narrower, and many of us resent it, and

I think many of you will resent it, especially if you think in terms of -- what did you call it last night? -- multiple --

DR. MYKLEBUST: Handicap.

DR. SMIGEL: -- multiple handicap.

To deal with these kind of people, you have to know a lot more than other people.

And in geriatrics they are doing the same thing. They don't think in terms of one sickness. They think in terms of many sicknesses. There is getting to be a field of geriatric physicians.

Let me go on. What this means, this joining together, is that we don't know who the client is. Is the boss the client? Is the head lawyer the client? Who do we work for? And a professional has to work for the client as if he were the only person. But maybe if you want to get ahead you have to please the boss, who is not the client. And this is another problem that is involved here.

All right. Now, there are other difficulties in defining a profession. One of the difficulties is that the difference between occupations and professions is getting smaller.

There is a man named McKeever, who I say is the last of the "know-it-all" sociologists, because he is a political scientist, he is a philosopher, and he is a sociologist. And he doesn't worry about the new terms.

He is also I think 80 years old.

But he is one of the last of the all-around sociologists. And what he found was that the pure economic associations, which used to worry just about pure profits, are now not just only worried about pure profits but they are worried about society. So that Macy's, when it has its Thanksgiving Parade, has a parade that it no longer needs for the advertising purposes but has it as a public service as well as whatev advertising benefits there are. But Macy's doesn't really need that expensive parade anymore.

The physicians, on the other end of this, have an association working for them in terms of the pure economic. While they keep up their other functions, they are working in such a way that the professions are going closer to the occupations and the occupations are coming closer to the professions.

There is a man named Nelson Foote who now predicts the future for General Electric so they can know what kind of electricity, let's say, ladies will want in the year 2,000 In other words, he is trying to predict the future sociologically. He wrote an article, when he was doing something else about professionalization in Detroit and said eventually ever body will be professional because we get out so many of these jobs.

Some other people -- like Wolensky, who wrote an article "Professionalization of Everyone?" -- find that isn't

A man named Gude working with librarians found that wasn't the case either.

This brings us to some of the definitions.

In a book called "The Academic Man," a man named Wilson gives this definition and gives the following criteria:

You have to have prolonged and specialized training -- that is the first of this -- based upon a systematic intellectual tradition. You just can't pick it up overnight.

Prolonged and specialized training based upon a systematic intellectual tradition and not acquired through mere apprenticeship.

So, according to this definition, lawyers were not always professional people. They became so later.

And this prolonged and specialized training is usually attached to some academic institution. That is why the chiropractors and the eye doctors try to get involved with academic institutions. And that is why the chiropractors keep adding years to their educational requirement in an effort to gain recognition.

The next one is that we have rigorous standards of licensure. There has to be some licensing procedure, some recognition that this is important by the State, and the fulfillment of which often confers upon the functionary a degree or title signifying specialized competence.

So that the public knows that the Government has said

"You're okay for whatever monopoly you have over the body, which is your area, what you can do what with."

Of course, each of the professions fights over these areas, so in psychiatry there is a big fight, or has been a bi fight, between the clinical psychologists, the psychiatrists, the psychiatric nurses, the psychiatric social workers, and so on, all fighting over the same area.

So the physician is licensed, the CPA is licensed, the lawyer is licensed, and now more and more people are getting certificates, and pretty soon the certificate will become a cheap kind of licensing. We won't recognize it. Because too many people are getting certificates in too many things, and it gives it an inflationary look.

The license really gives you access to some part of the body, and you say, "This is mine, and that part of the work is your monopoly."

Another thing that we have is the difficulty of testing the intricacy of work. If the work is simple, then others can tell what you have done wrong. If the work is not simple, then the public doesn't know. In fact, it's hard for your colleagues to judge you unless you have worked as long as people have in the law firms together before they become partners. But mostly you can't tell.

How do you know if a physician has done the wrong thing except in some cases? Even when they say there is a malignancy and there isn't, that doesn't mean he was wrong. Maybe they have to find it out. Maybe this was the only way, and only his guess was wrong. Maybe he still did the right thing. It is very hard to find out.

Now, there are simple things. If he doesn't wash his hands before the operation, he is wrong.

And there is one case where a guy sued a physician in the Navy because at the second operation he had for the same thing they opened him and found the towel with "U.S. Navy" on it. And this is an actual case, and it is in the lawbooks.

Well, obviously he was wrong.

But really you can't tell. Certain things you can't tell. And when you can't tell, this means it is harder for that occupation to become a profession.

Another criterion is the absence of precise contractual terms of work. Now, this is changing, because people do have contracts now. But still professional people are fighting not to have the contracts as defined as they are for workers.

You know what is happening in every big factory. There are hundreds of professional people. Now, RCA has engineers and chemists and so on. There are two or three books on this subject about the contract work and how the professional fits in.

There is a war going on right now between the professionals and the contractors.

The absence of precise contractual terms of work.

Then limitation on self-interest, which is one of the major points. The practitioner is there not to make money, though he has to make some, and what that is differs under different circumstances. His major point of view is supposed to be service to the community, service to the client, service to whatever he is being professional about.

And every occupation has a professional association. Every profession has a professional association. Some of them that are not professional try to have professional associations because they try to meet the criteria of professionals. But all of them have it.

Most of the definitions that I had-- And I collected 20 or 30 of them and have just given you, and I am giving you the parts that usually overlap in all of them. Most of the definitions have something about professional associations, because professional associations have to be in a sense the policeman for the association. Because if you have people breaking canons of ethics, then that reflects on everybody.

So at least the élite of every profession want codes of ethics and want an association to police them.

In New York City, the City of New York had 1,140 cases, and 44 finally came up to the Court of Appeal, which is the way it is finally settled.

DR. KIRK: What is the difference between the AMA and the Teamsters Union? Is one an association and the other a union?

DR. SMIGEL: This is the part I left out in McKeever' scheme. I left it out.

DR. KIRK: Are both of them unions by a different name?

DR. SMIGEL: No, until recently unions were only interested in self. They were bread-and-butter. More recently-- And one of the reasons Reuther tries to pull out of the AFL-CIO is because he wants to do more in terms of societal interests.

But the professional organization have a journal, they have meetings, they talk about canons of ethics which are supposed to protect the public. And so that you are going to come to finally is that most of this is on a continuum.

This brings us to the point. In other words, only in the core of the professions can you say this is a professio and this is an occupation. But it is on a continuum.

Actually, there are some studies to show that you ma have a number of continuua, and you probably have to add it up in some sort of a fashion and then make arbitrary decisions about what you are going to call a profession. But it is on a continuum.

What is happening now is that a lot of people are studying not professions but professionalization. What is the process an occupation has to go through to become a profession?

Gude said to the librarians, "You will never become a profession" -- because he thinks their work is so simple, in that we know it, and even though we don't know where the book is hidden that's a simple matter too.

He says that if we come to them for it, then we haven't really done the work in our field. Now, maybe for a child they may have something. But he didn't feel that.

At any rate, he didn't say they weren't becoming professionalized. He says that by licensing, which they don't have yet but which they want, by the degrees they have to take and I think they already have a Ph.D. and some of them are going on to that -- they are becoming more and more professionalized. But now they have an association, and now they have requirements, and now they are trying to force universities and other places just to hire professional librarians. As soon as they have enough professional librarians -- as soon as they have enough they will be all right.

DR. KIRK: What do you mean by "all right"?

DR. SMIGEL: All right from their point of view. That is, they will be closer to professionalization. I don't know that they need this. And Gude says they really don't. But from their point of view they do.

How much time should I take? Five more minutes?

DR. MYKLEBUST: Yes, five more minutes.

DR. SMIGEL: Here is one that someone did for socia workers that I will give you very briefly.

Systematic theory. That is part of the education, almost the same as before.

Authority. And that is the place where the custome is not always right. He has to listen to the profession.

Community sanction. An occupation wanting to becom a profession wants community approval. They have to be recognized. Otherwise it doesn't matter almost, except to you. In other words, you are saying you are a profession, and they are not saying it. If they are not, you don't get the recognition.

Control over its training centers, over admissions, which can be good or bad.

Confidentiality.

And a monopoly over a certain area.

Regulative code of ethics.

And something he hasn't talked about but which I think is very important -- the professional culture, values, norms, and symbols, which take a long time to develop. But each profession has it.

Now, the two that I studied, the two that I know most about, have it for the élite at least. In lawyers it was this whole business of the need to be politely argumentative and to work your point until you are convinced that you are wrong.

In academia, it is academic freedom and the norms t go with that.

In a book that Lazerfeld wrote about the academic mind, which he wrote after McCarthy was in power, and where he wanted to see what McCarthy had done to freedom of thought which is part of our job in any profession, he found that th more élite the school, the more McCarthy attack it and the more it attack McCarthy.

I think it is true about every profession, if we knew more about them, that every profession has certain rule and regulations that can keep it free. And for those that are confident, it does keep them free. But you have to be confident. And you have to be an élite. And the élite have to try to instill this in others, and this is a tremendous job.

Because if you look at Carlin's book on the solo lawyers, these lawyers are struggling to exist. These lawye are struggling to eat. They are not going to worry so much about the refinements in a culture.

Well, there is more, but let me try to sum it up simply by trying to say again how difficult it is, first, to define a profession, but that there are enough clues for us to get a picture.

Second, I believe a profession is on a continuum.

Third, the more heterogeneous you are, the harder it is, especially if you are starting in to form one, but that this may not be the final limit, since medicine and law, the models of the professions, are now getting more heterogeneous than they once were.

So that's my talk for today.

DR. MYKLEBUST: Dr. Smigel, thank you very much for this most enlightening discussion.

I think that some of us here would feel that in the first place it's very broad in its concept and helpful, a little disturbing perhaps in the way that Dr. Smigel is able to look at a profession and say where you fit, where you fall, what you are, what the problems are, and so on.

This is very helpful to us, and we appreciate it very much. We will probably have time for some discussion later.

I now feel that we need a cup of coffee. Could we take a little coffee break now, please, before Dr. Kirk?

(Whereupon, a recess was taken.)

DR. MYKLEBUST: Well, we'll go right on now. Sorry we have to try to keep on schedule, but you know this is essential for all of us.

I now have the pleasure of getting Dr. Sam Kirk before us with his presentation. As you know, he is going to discuss the problem of the need for clarification.

Sam.

DR. KIRK: I appreciate Mike's title -- the need for clarification -- rather than just clarification. If I had to clarify, he would have given me an impossible job. (Laughter

I do have some introductory comments about how you take on a problem and rather thoroughly cover the subject.

But I want to say first off the record --

(Remarks off the record.)

I thought I had better start out by indicating to you my confusion. I think Mike asked me to discuss something about the problems of clarification because he heard a speech I gave in New York entitled, "Are We Confused?"

I think this is a very confusing field, although at one time it was not a confusing field.

I remember many years ago when I was maybe 22 or 23 I got a job teaching in a school near Chicago for delinquent retarded boys, and I got that job. They called me resident teacher.

Fortunately, in those days there were no certifications for teachers, so I could get the job and explore all kinds of things.

At this particular place, which was in Oak Forest, Illinois, I read a case record of a boy who was 12 years old, couldn't read, became delinquent, IQ around 80. And someone had stated that this boy should be diagnosed or was diagnosed as a case of very severe alexia.

I didn't know what alexia meant, so the next day I went to the library of the University of Chicago and picked some literature and began reading, and one was Marian Monroe work at the Institute for Juvenile Research. I studied that

My particular job was to work in the afternoon, pu the boys to bed with the nurses, and do a little recreation, try to teach them. It was sort of a heterogeneous job -- and also bus-boy -- since I had classes at the University of Chicago in the morning. So I called this boy after the kids went to bed at eight or nine, and I began experimenting with teaching him how to read. And I found out he could learn. And within about six or eight months I had him reading up to about third grade.

I was so proud of this I wrote a letter to the Institute for Juvenile Research saying I really cured this k

And they asked for him to go in there. And he wen in to the Institute for Juvenile Research, was examined by Marian Monroe, whereupon I received a letter asking me to report the techniques I used for teaching this child and how I found out how to teach him.

I went down there and said I had read some of the materials and applied some sort of a phonic system to him an found out he could learn, and also that I wanted to learn something about diagnosing reading disabilities, and I would write the report providing they showed me how to test kids.

Well, within about four months they paroled this bo and put him in the public schools, back at home, because he was a juvenile court case.

At that time I thought, you know, that this was rather simple -- kids that can't learn.

I picked up a few more children and thought I could teach them to read. And the problem was relatively simple.

I got a job in Michigan to do research on reading with mentally retarded and other problems. And when I got there they began referring all kinds of children, aphasic children, children with perceptual handicaps, as they are called now, but I didn't quite know what they were, behavior problems, fingernail-biters. You know. It wasn't just plai diagnosing reading.

So my job was to do research half a day and to do some kind of treatment or remediation the other half-day. And we had some students from the University of Michigan.

That's how I got started in diagnosing remediatio

Well, naturally, at that time I hadn't had any wor in this field, and the language problem was quite important in some of these children. So I went in to Wayne University, took a course in speech correction in order to find out wha to do. I can tell you that that course didn't help me very much.

Then I went into the University of Michigan and took two seminars with a Dr. Muyskins, who was head of the speech pathology department. He had a big beard and ran for Mayor, a he was a real character.

Do you know him, Mike?

DR. MYKLEBUST: No.

DR. KIRK: He was a real character. He was theoretical, was physiological, very physiologically inclined, and explained many things in terms of physiology.

And then later, after I got my Ph.D., I took some work in the deaf, because they were working in the language area. Two courses.

I had a workshop for the visually handicapped that I took one summer.

The only area, Mike, that I have never taken a cours in is in the field of mentally retarded. So don't ask me any questions in that field, because I have never had a course in that.

A lot of people have been saying to me, "Why don't you send your credentials in to the State Department of Public Instruction and see if they will certify you as a teacher of mentally retarded, since everybody uses your book for trainin teachers?"

I say I don't want to embarrass them. I'm sure they will turn me down flatly. I haven't had the practice teachin or the sequence of courses we use to train teachers.

That's just a little bit by way of introduction to indicate that at one time I had quite a few answers to these, and it was rather simple. You'd take children with problems and try to do something for them, reading and visual perception and language and that sort of thing.

One of the areas I was particularly interested in was the theories in physiology, so after a few courses in physiology and physiological psychology I ran an experiment on rats -- mostly because they wouldn't let me cut up brains of kids that were left-handed, mixed dominance, and that sort of thing. And I had a lot of fun teaching rats to read. You know, they can jump at a yes versus a no. And you test their handedness, cut up their anterior lobes, shift their handedness, and see what happens to their visual perception.

I really got no place on that. I mean after about two years of research in a physiological laboratory I couldn't get very many cues to this transference to the kids themselves.

The next thing that faced me is when I ran a pre-school for mentally retarded children. Mental retardation is kind of a simple deal, you know. You can define it by IQ. And if you accept the hypothesis that a low IQ shows poor integrity of the nervous system, then these children have poor integrity of the nervous system by inference from a low IQ.

But when you start setting up a school for young kids that test below 75 IQ on two or three psychological tests and you begin to work with them rather intensively, you find that your diagnosis of mental retardation is a little bit simple.

Just to give you one example, because I think it falls more under the caption of learning disabilities than anything else, here is a girl referred by a pediatrician saying, "I think this girl, whose IQ is below 50, from the psychological clinic, is a little bit too low for your pre-school, but you might take a look at her. I recommended institutionalization, but the parents refused. You might take her since you are looking for kids at that age."

This girl has many physical problems. First, we have had an operation at the age of three for cataracts, to remove cataracts. She has a marked case of nystagmus. She is diagnosed as legally blind by the ophthalmologists. And she has a low IQ.

The etiology was rather clear. It was a case of rubella.

So we brought this little girl in, and her verbal ability looked to me like something a little higher than IQ 50. She couldn't see too well because her eyes jumped all the time.

We would ask her to do something, and she would stumble over things. Sometimes she could see, and sometimes she couldn't.

We asked the question: How do we train this kid? What do we work on?

Well, let's work on her area of greatest deficit. Apparently it is in the visual perceptual field. If you give her a long enough time, with her eyes jumping all the time, she could recognize something.

So I said, now, her verbal ability for her age and IQ is not too bad. She seemed to be rather a sociable girl, rather affectionate, and maybe we ought to see what we can do for her. What do we do about her vision?

So I concocted a little experiment in which we would take her up to a room and show her a picture of a cat and say, "Do you know what it is?"

If she didn't know, we'd say cat -- or dog -- and we'd come back to cat and then dog, and eventually we used a tatistoscope, gave her a minute to look at it, then half a minute.

We fooled around with this girl for around six months. At the end of that time we put all those pictures on the tatistoscope, and she recognized them in 125th of a second.

Boy! Legally blind? You snap these things like this. What a diagnosis!

I was so proud of our training her vision, you know, that I told the mother to take her back to the ophthalmologist who diagnosed her as legally blind.

She did. The ophthalmologist looked her over and said, "She's legally blind. She ought to go to a school for the blind."

The mother came back and says, "Legally blind."

So I called this doctor up. I said, "When you quit work around five," I said, "will you see me around five minut after five? I have a professional thing to discuss with you. I want you to examine my eyes."

I got this girl and took her to the office, and I said, "Doctor, I want you to see what this girl can do."

I had a book in my hand with pictures. I said, "Sharon, tell the doctor what you see."

She told him everything in the book, all the pictur the stories about the pictures. I did another one and anothe one and another one.

I said, "How can you say this girl is blind or even mention the word blindness when she can perceive that well?"

He says, "Her eyes are the same."

Maybe we are training a central process, because w really train speed of perception, recognition and speed of perception.

Now, this girl went on at the age of six and a hal into the regular school. They didn't have any partially see classes there.

At the age of ten, when we reexamined her, her IQ was 85 in the Binet and about 87 on another test. She was reading about middle second or third grade without special training or things of that sort.

Maybe she would have done that anyway -- I don't know -- without this training.

But I mention this case because here you are dealing with, let's say, mental retardation and find you have something else.

We had a little girl that came in, had been given an audiometric test. She's deaf. But somebody else tested her and says she doesn't have a hearing loss. And the EEG on her didn't find anything.

This girl had been diagnosed in a number of clinics. Some said she's deaf. Some said she's slightly hard of hearing. Others said she can hear.

But she couldn't talk at age five, couldn't say anything. And is that due to deafness?

Well, we fooled around with her, trained her as you do a deaf child with receptive aphasia, expressive aphasia. And within about a year or so we made considerable progress with this girl in the auditory field.

So I think this is probably one of the problems that we have in clarification: What is this category we are calling learning disabilities, or psychological disorders, or whatever you want to call it? What are you going to call this girl that needed remediation in speed of perception to counteract her nystagmus? Her eyes jumped 15 times to see something or recognize something. Can we train her to see these and recognize these objects with only one jump of the eye in between whatever happens in the central process?

Because I'm sure we didn't do anything with her peripheral vision. We didn't change her nystagma. She still had a nystagmus. She still had some pure visual acuity. I don't think we did a thing with that, but I think we did have her use the brain, so to speak, the central process, that could compensate for this peripheral handicap.

Now, we have, as everybody knows, bandwagon effects on everything. Many years ago people preferred to call it brain-injured instead of idiots or imbeciles. I mean it's kinder to the parents to say your kid if brain-injured than to say he's an idiot or an imbecile.

They kept saying, "My child is brain-injured." And this is a kinder term for them. If he is brain-injured, they have an explanation for mental deficiency, and it isn't as harsh as the terms "mental deficiency," "idiot," and "imbecile."

So we changed the words to "mental retardation" and things of that sort.

So we have all kinds of disabilities coming into this particular rubric, whatever it may mean.

At the CEC convention in Toronto I got a telegram from Senator Morse asking if I could come in to Congress and explain to the Senators what we meant by learning disabilities, that there was considerable confusion. You were there, weren't you, Selznick?

DR. SELZNICK: Not that particular one.

DR. KIRK: They wanted some clarification, because the pressure from the outside was so great they had to have some clarification.

So I said, "Well, this is a broad field, and I don't know that I can. I will bring anybody you want."

He said, "Bring anybody you want with you."

So I called Richard Paine, who was a neurologist in Washington and who does a lot of work with children, a well-recognized person, and asked him if he could testify about what he thought from a neurological point of view.

I took Jean McCarthy from the public schools who is running a program -- we have a practical public school program -- the neurologist and myself.

We went down there and gave them little speeches. They asked questions: "What is the difference between mental retardation and learning disabilities? How do you pinpoint this field? How do you differentiate it from the disadvantaged and things of that sort?"

Well, in my testimony -- I read it later, and I still believe what I said -- I made the statement that these children have discrepancies in psychological functions, that some grow and some don't, and that we have to determine the learning disabilities by determining whether a child has psychological deficits inhibiting his ability to learn.

And I also said that some of these children, of course, have correlated physiological problems.

I didn't use the term "brain injured," but I used "physiological."

Now, when Wayne Morse wrote the Elementary and Secondary Education Act, they put the pressure on, and he included -- with deaf and blind, crippled, and so forth -- learning disabilities. There is a caption called "Health and Other Services."

So when he wrote it up he said, "Professor Samuel A. Kirk from the University of Illinois has produced research evidence for us in which he said that this condition is physiologically based or has physiological deficits."

He changed the term "psychological" to "physiological."

Now, that created a real confusion for the Office of Education, because if it is physiological then it is out of the hands of educators and has got to be in the hands of the MD. Therefore, if we are going to deal with these kind, it ought to be under the medical auspices because it is written in there "physiological."

I said, "Did I say that?" I could, you know, under the pressure of testimony. And I read it carefully, and I did say-- The only time I used "physiological" is that, of course, some of these children have-- That is, there are many reasons for this, and some of them have physiological correlates.

And Richard Paine told them the same thing. I read his testimony. He told them it is an educational problem although there may be some children-- They can find a lot of other children where they can't find any neurological deficits. And he practically told them what I told them. It is an educational problem in children.

But, anyway, this needs clarification not only between us -- and we will have trouble clarifying, as you will notice -- but before the general public, and we also have Congress, the Office of Education, the Neurological Institute.

Unless this is clarified, we are going to go off into millions of directions.

You become flabbergasted, you know. Mike and I attended the first meeting of ACLD in Chicago, before it was that, and the meeting was to call together all these associations called "Funds For the Perceptually Handicapped,"Society of Brain-Injured Children, Society for Learning Problems. I guess there were about a dozen different names for parent groups.

So they met in Chicago, and Mike and I both presented papers to them. I don't think we differed very much in our point of view, if any, at the time.

It ran something like this: "Now, we know that there are possibly correlated biological factors. If I were a research man and was interested in the biological correlates of some of these psychological and educational deficits, I would tend to use some sort of brain terminology, because that's what I want to do when I connect the brain with behavior, or the brain interface, or whatever you want to call it."

I said, "If you are interested in doing something for these kids in a learning-teaching milieu situation, then it might be better for you to use some sort of a behavioral term like 'learning disabilities' or 'psycho-educational work' or something of that sort, because you are not really going to do anything with the brain particularly -- unless if some of them are given drugs you might."

Well, they got together the next day, or so forth, and came out with the Association for Learning Disabilities.

Then they got ambitious enough to run a meeting, and they ran a meeting in Tulsa and got a lot of speakers, pretty good speakers I think, from all over the country, England, and other places.

The big complaint about that meeting was that the hotel in Tulsa could not hold the crowd that came to listen to this Association of Learning Disabilities. It was jammed.

They couldn't get luncheon tickets. They had plenty of luncheon tickets, but not enough.

The New York people said to them: "This is a hell of a place to go, out on the farm here, and have a meeting of this magnitude. Why don't you come, you know, to a respectable city instead of out here in the oil wells of Tulsa?"

What is Tulsa? 200,000?

DR. MYKLEBUST: About.

DR. KIRK: They didn't say it exactly in those terms, but there was considerable complaint.

They said, "Okay, New York. You run it."

So last year, in March, they held an ACLD meeting -- some of you were there -- in New York. And they took over the Waldorf-Astoria Hotel, which is a tremendous hotel.

DR. BLAIR: It wasn't big enough either.

DR. KIRK: Then the fire marshals stopped the elevators going to the convention floors because they couldn't hold that many people. They had 6,000 people registered that came from all over to learn something about learning disabilities.

This is a parents' organization, practically, with the help of some professionals.

And now they are going to have it in Boston next year, and I'm not sure the Boston people want it. They are resisting it because they don't think they can hold the ten thousand they might descend upon them.

And there was as much complaint. They had more complaints in New York than they did in Tulsa. Here's the "big city" in the United States.

After a day or so they took over another hotel and moved some of the meetings there. But, you know, the convention was over before they got organized.

But I just mention that as a public pressure phenomen

Gallagher tells me in Washington that 75 per cent of the letters coming in on special education to the Commissioner of Education are in this area. Pressure is very hard. Many people say the Federal Government isn't doing anything -- in spite of the fact that the U.S. Office is giving grants. Mike is chairman of the board, and they hand out a million or so dollars a year for training people in learning disabilities. They say nobody is doing anything.

We have a million dollars for research. That isn't very much, a million dollars. Probably it ought to be five or eight million. But, anyway, there is a start there.

And I think particularly in Washington, unless we are able to delineate the field in some way to make sense for Federal agencies to subsidize, we are probably going to be a little bit in trouble.

Because, like education in general, who is an educator? Everybody is an educator. You know, every lawyer has gone through school, and he knows all about education. Every plumber has gone through school, and he knows everything about education. So everybody knows about these fields.

And what is it? And I'm not sure. And one of the reasons I told Mike I was really happy that he is taking a little initiative to get some people together is I think we ought to have this and a number of other meetings and battle ahead until we come out with something to keep it rather clear to the public.

I think one of the major difficulties that we have is that every child under the caption of "handicapped" has a learning problem. A deaf child doesn't learn to read very well. Is he a learning disability? Is this what we are talking about?

Now, many of those who came to New York had some handicapped children, the cerebral palsied, the deaf, the blind, the crippled, the mentally retarded. Are these really what we talk about when we talk about learning disabilities? Is that the category? Do we diagnose them by exclusion?

We say, "Well, no, when we look at this kid and we find he's deaf, we have a program for the deaf. We have a curriculum for the deaf." I mean there are people doing that work right now, and, therefore, we won't call him X term, whether it's learning disability or something else, because we do have a program for this kid.

The reason this problem arises is because so many kids come in to the hopper, and the ear people say he's not deaf, the people in the blind say he's not blind, the mental retardation say he's not mentally retarded, but the kid isn't learning or can't talk or something of that sort.

What will we do with him? He is handicapped. He isn't communicating. He isn't doing a great number of things. Something ought to be done for him.

"I know something ought to be done, but, I'm sorry, I just take care of the deaf," or "I just take care of the mentally retarded." You know, we have these categorical classes in the schools.

Then we have this mass of kids that don't fit into any of these. The multiply-handicapped that you are going to talk about is one group.

And so we have to do something to kind of delineate the program.

Gallagher and I were talking about this, and this is partly his idea of what he is going to recommend, you know, after about an hour's discussion, and it runs something like this.

We have a group of kids that are educationally retarded in the schools. We have many of these disadvantaged kids. We have many kids that haven't had an opportunity to go to school, kids that go to school and something happens in the instructional process and they don't learn. Are these learning disabilities?

Is every kid that is retarded let's say in reading a learning disability? And how much retardation?

And every kid that doesn't learn reading, writing, and arithmetic in school because he hasn't been there? I have seen kids 15 years old that come from Arkansas with ten other kids in Champaign, and you find out they have never been in to school. And they are ten years old. Are you going to put them into kindergarten? Are they learning disabilities?

Then we have another group of kids that we identify sometimes as neurological handicapped. We have the cerebral palsied group. You have many kids where you can get a definitive diagnosis of neurological handicap, developmental or otherwise. Are these neurological kids learning disabilities? Are all neurologically handicapped kids learning disabilities?

I don't think the answer is yes. It's probably no.

I had one cerebral-palsied girl who got her master's from Northwestern and her Ph.D. from us. She was a spastic. She had a speech problem. But I wouldn't call her a learning disability. She learned everything up to Ph.D., even though the standards are low at the university. She at least got through.

So is every kid that has a neurological handicap a learning disability? The answer is no.

Is every kid that is retarded educationally a learning disability? Probably no.

Now, it is probably this area here -- (indicating at blackboard) -- if we can define the overlap of a child who has had we would say proper educational environment, has potentially normal intelligence, who under these circumstances has not been able to learn whatever we want him to learn in language, reading, speech, whatever we want to classify under the caption of learning disabilities.

Does this kid have a neurological handicap? Well, maybe in some cases, yes. In some cases we don't know. In some other cases, probably not. Maybe it is genetic. Maybe it's something else. You see, we don't know.

Now, the thing to do is: How do we define this overlap group, you see, between this and this (indicating), because one group calls it brain-injured kids, another group wants to call it something else, you see, and there it may not be brain-injured. It may be genetic. It may be something else.

Now, we could say -- and this is the point of view that I have held -- that we have to operate primarily on a behavior level. If this child has abilities and disabilities and we can define the disabilities that are remediable, like this girl-- I didn't have tests to say she is high here and high here, just a clinical impression, like a lot of clinical psychologists do, you see, which is a very valid approach. You don't have to have a score to know this.

But we knew that she just couldn't recognize objects and things with her eyes and that there was a biological base for it, you know, with the cataracts, and that the biological base I couldn't do anything about. And she had been to pediatricians and ophthalmologists, and they didn't do anything about it.

But we introduced stimulation of the environment on a behavioral basis in order to train her deficit, and we got some place with her.

Now, if we can define this area in some way concretel enough that it would be acceptable by legislators, by others, and by schools, the way we have let's say deafness-- And we read that literature in the deaf, and they don't agree, you know. They haven't got it, as a matter of fact, that this is deaf and this is hard of hearing. There are grades and everything.

What is mental retardation? Well, we had this instrument called an intelligence test, you know, and the State laws many years ago said 69 and below. So you slapped them with a Binet, and if you got 69 and below the legislature says, "We have got a figure here. Children who are 69 and below we put in classes for the mentally retarded."

What ruined that 69 is that a lot of screwballs went out and developed some other kinds of tests, and they get 69 on one test and get 84 on another, and then they don't quite know. What will we do? Hide this in order to get them in? Or shall we throw this out in order to not get them in?

I mean this was a game, you see, with these figures.

But we got away with it, you see. We have classes for the mentally retarded. We have classes for the deaf. We have classes for the legally blind, classes for the partiall seeing -- 20/200 if I remember.

DR. SELZNICK: That's right.

DR. KIRK: 20/200. Or 70/200. Is that correct?

MISS TAYLOR: 20/200 is the one you choose to use. That's the definition of legal blindness.

DR. KIRK: This is what we put. We tell the legislators. 20/200. This girl was 20/200 that I was talking about. Legally blind. What does it mean? It's about as bad as the 69 IQ. But they accept it, you see. Maybe they are getting to sophisticated.

We are getting into new fields now in special education.

I was asked to review some projects they had approve for Title III under the Elementary and Secondary Education Act last year. Maybe some of you read it in one of the Congressional Reports. I got hooked for one in special education, innovative projects in special education.

Before I looked at those 30 projects or visited a few, I said, "If I were to set up exemplary innovative programs and needs, you know, what would I say?" I wanted to do a little prophesying before I read those reports to see what the people are doing, you know, asking for.

It came out about what I thought, you know -- emotionally disturbed, learning disabilities. These are the two new fields that have hit the market in the last four or five years.

And it's exactly what it turned out. How many projects did they ask for throughout the United States out of millions of dollars for the deaf? One. Somebody wanted to go down to pre-school and see if they can teach kids in the home. It wasn't very exemplary or innovative.

How many in the blind? I think one. Somebody wanted mobility training, but he said, "We have mobility training at age 15." He wants to reduce it to 14 and 11 months, you know, or this "great invention."

Is this all on the record?

But I mean this is it.

What did we have in mental retardation? Somebody in Minnesota wants to set up a sheltered workshop. That's "innovative" and "exemplary" or things like that.

But, you know, just about one thing here and there in each of these fields.

But when it came to emotionally disturbed and learning disabilities, that was about 80 or 90 per cent of the money they asked for.

But how were they running? They were a little confused. One five-county area in one of the Southern States asked for a million dollars -- and got it -- to set up diagnostic remedial clinics. So they set up psychiatrists, psychologists, and social workers in one center. Then they had a satellite in each unit. Then they had a liaison officer in each school to get the kids to the satellite. And then they had remedial teachers, and they talked about mental retardation and crippled and deaf. They took the whole area of special education under the caption "Learning Disabilities."

I wonder how it's working really now, because they took in everything.

And, you know, under Title III there are a lot of projects for diagnostic and remedial programs in schools. I'll bet there are $10 or $15 million going into those schools -- maybe more than that. And what are they doing? I'm interested.

They asked me to review some of them this year, and I told them I was taking a leave of absence from that and everything else, though I am very interested to see what they really are doing in some of these centers and how do they define their area. Are they interested inthe mentally retarded, you know, under the caption of learning disabilities? Are they going to set up a program for the mentally retarded?

Do you know, Corrine?

DR. KASS: No, I don't.

DR. KIRK: But we have this sort of thing. We have a lot of kids that are retarded educationally. They are not up to grade in educational things. But we have a Title I to do that. We can't take over the whole field of education in special education. We have to limit ourselves to those areas that require rather high specialized training and remedial programs.

Now, the average teacher doesn't know exactly what to do with, let's say, using the common term, the receptive aphasic kid or the expressive aphasic kid in the language field. They don't know how to start, how to go. You have to have somebody who has some kind of training and some methodological approaches of some sort to the development of speech in mute kids, so to speak, even though they can hear and see.

So I say if we can define this in such a way not that 40 or 50 per cent of the kids-- Because we have other agencies to handle the minor problems. What happens in most of these remedial programs? I have seen them in schools. They are disadvantaged kids. There's nothing wrong with the kids. They're probably all right. When I say "nothing wrong," I really mean it.

We had one experiment -- or two of them, as a matter of fact. We took four-year-old kids from these public assistan rolls, you know. Their average IQ was about 96. We took another group with average IQ of 96. You say they are not of normal intelligence because they are not 100, you know, or something. Their average on the Binet is really 107 at that age level to be average.

But, okay. You put them in a pre-school under certain kinds of specialized education. And this group goes up 17 points in IQ (indicating), and this group goes up 15 points (indicating).

This group we send to kindergarten. After one year they drop one point in the regular kindergarten.

This group we keep under specialized training, and to my surprise they have gone up eight points. So we have about 24 points' difference between four and six in IQ, with an average IQ of 120 for these little disadvantaged kids.

Now, was there something wrong with those kids, or is it, you know, cultural and environmental up to a certain point?

So I say there's probably nothing wrong with the kids themselves. They don't have developmental deficits. And if we give them a fairly good environment and training and schooling, they will probably move.

Because every form of intervention-- Take the Montessori system. You get about a eight point increase. Wherever you intervene with disadvantaged kids, you get a six-to eight-point increase in Binet IQ.

If you add something to that intervention, with something more programmed and systematic, you get higher acceleration in mental development.

That's about all. I think our major problem is to delineate this group (indicating at blackboard).

There are a lot of controversies. One controversy is the differentiation of the learning case from the mentally retarded, the deaf, the blind, the crippled. And that's confusing when you are restricted to more professional groups. But how are you going to define this group operationally in such a way that parents and teachers and legislators and others will understand it and the practitioner in the school will say, "This child belongs here, but this child needs more specialized training because of this"?

Thank you, Mike.

DR. MYKLEBUST: Thank you very much, Sam. As usual, Dr. Kirk has given us a very basic statement of the many issues involved.

And, of course, don't forget now you are going to have time and opportunity to comment.

But, as you know from the agenda this morning, we have asked some people to give us statements of issues, and we will continue with that.

Next we have Dr. Cass. As I said last night, it is through her interest and cooperation that we could have this conference. Because of her important responsibilities in her office in the U.S. Office of Education, I asked Corrine if she would give us some comments from that point of view. That is why this has been listed as objectives for the conference -- to gradually try to get down to the basic issues, though Dr. Kirk has already certainly gotten us very much involved in them.

Now, Corrinne, will you go ahead with any direction then that you want with us?

DR. KASS: Thank you very much. I am very excited about being able to exchange ideas with you.

What I would like to do is give three general objectives, three questions which I hope will be answered or partially answered in this conference. These are objectives which Dr. Myklebust worded very well I feel.

Then I would like to expand on these by sharing with you some of my experiences at the Office of Education to see if we can note some interrelationships here.

The three objectives then are these:

One, what definition of a learning disability at this time seems most advantageous and beneficial for national purposes?

The second question is: What constitutes an interrelated type of problem? That is, in the case of the deaf blind, how much deafness and how much blindness should be present before a given child is most advantageously considered to fall within the category of the deaf blind?

Another example is that of a child who is emotionally disturbed and also has a learning disability such as dyslexia. How should these two involvements be defined in order to include the child under the category of the area of interrelated handicaps?

And the third question is: To what extent can centers of training meet the needs for trained personnel in the areas of learning disabilities and interrelated handicaps? In what ways should such training programs be augmented and oriented to more successfully meet the urgent demands of the nation at this time?

DR. KIRK: I wonder if you would repeat those? I didn't know you were going to put those questions. Just briefly.

DR. KASS: All right. One is: What is the definition of learning disability, or what definition of learning disability at this time seems most advantageous for national purposes?

Two, what constitues an interrelated type of problem? That is, in order for a child to be labeled as deaf blind, how much deafness, how much blindness should there be? How do we define an interrelated problem?

Third, to what extent can these training centers, university training programs, be augmented and oriented to meet the urgent demands of the nation at this time?

I should like to expand these and make some points from my experience.

The first point I would like to make, or the first question I should like to ask, is: Is there such a field? I think we are going some basic assumptions. I think we can assume that there is such a field as learning disabilities. We do hear this term. We find that there is a great deal of interest nation-wide.

You have heard about the mobs at a national conference such as the ACLD had in New York City. Many meetings and conferences of the CEC are devoted to learning disabilities. These are very popular.

The American Psychological Association in their next meeting will devote one institute or one division meeting to learning disabilities, a four-day-length institute.

So that many organizations, many professional groups across the country, are assuming there is such a field. The interest is great.

At the Office of education I have found that the funding of the teacher-training programs is done under my office, which is called "Interrelated Areas and Learning Disorders," but since coming there I sense among my friends in the Government and in organizations such as CEC a shifting about, whenever the word "learning disabilities" is mentioned, and I have learned a new vocabulary at the Office of Education.

Certain words are used rather often. I have heard learning disabilities called the "sticky area," the "bucket of worms." I have heard that we must "keep the lid on" this area.

I have heard that we must "bomb out" learning disabilities, that we must "get rid of the whole smear."

I'm exaggerating a bit, but these are words and phrases which are very common.

It seems to me that this uneasy feeling, this defensive laughter is pretty much centered in Washington, very interestingly, and even to the extent that we find it among the Washington universities, the special education departments in some of the universities there.

So it seems to me that, while we find a basic assumption generally that there is such a field, that there are such children, we also find a feeling that this may be the fad of the moment, that this may be a bandwagon which will disappear, that this is something about which we are somewhat embarrassed in special education.

The question then has to do with where this area belongs. We find a great deal of overlap here in Washington among the various agencies. You heard about Title III, supplementary services, under the Elementary and Secondary Education Act. Many of these services have to do with learning disabilities.

Our friends at the NINDB, the National Institute for Neurological Diseases and blindness, are interested in this area.

So I think, number one, we must ask ourselves the question: Is there such a field? And what responsibility do we in special education have toward this?

A second question we must ask is: How do we define it?

I think, for the most part, professionals who are doing work in what they call learning disabilities have a professional definition. The concern nationally seems to center around a national definition, a definition which will give learning disabilities its place within special education.

The Office of Interrelated Areas and Learning Disabilities is an addition to the structure, the organizational structure.

And I have found too since I came that wherever anything within a bureaucracy is added, we have some unrest, because it changes the organizational structure. It means reallocation of funds. It means that the funds must now be divided in one more way than previously done.

So the hue and cry within this structure then is, "Please define your area. Show us how you fit here. Show us that you do, in the first place, and how you fit, so that we will not be losing anything we already have."

At the moment the definition for handicapped children in the law lists a number of handicapping conditions, among these mental retardation, deafness, blindness, crippled, and the final phrase being "other health impaired which require special education."

Since I have been asked so often to define the area of learning disabilities, I have noted in some historical research that none of the handicapping conditions are defined within the law. There are no legal definitions of these handicapping conditions, nor is there a definition of special education. So the only thing I can figure out is that everyone is very comfortable with the usual definitions of mental retardation, deafness, blindness.

In other words, everyone takes it for granted and makes the assumption that these are defined.

We have rather quantitative terms within which the field works -- the IQ in mental retardation, the decibels in the deaf, the number of feet one can see in the blind. But there is not yet any quantitative way, any shorthand quantitative way, of defining or describing learning disabilities.

So I think this question is a relevant one and one which forms one of our objectives. That is, how do we define learning disabilities so that it is useful nationally, regardless of what we might do professionally or of the continuum which we would use professionally?

A third issue or question is: What kind of services are available for the children whom we call "learning disabilities"? I think this forms probably a major portion of my work, this very question, which comes from all parts of the country, the question of what public school services are available for these children, or what private services.

Each time I get a rather sinking feeling, because it is so difficult to answer these questions.

Most of the services I find for children with specific learning disabilities are private services and very expensive, extremely expensive.

The public school services are rare. There are some communities which have a rather good coverage, but very few.

For the most part, parents and professionals must look to private help. And included among the private services are many of our so-called fads and panaceas.

We decry the fads and the panaceas, the "creepy-crawly" methods, and so forth, and yet we must remember that in many communities, in many cases, these are the only services which are available.

We find in this field I think a variety of labels

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attached to these services, so that one private institution might say it provides services for children with dyslexia and brain injury and so forth. Another one might say, "We provide services for children with learning disabilities" -- and another one for language disorders.

All of this is very confusing to the clients, to those who are looking for services.

In one sense it is rather amusing to get the various phone calls and letters asking about services for children who have been diagnosed as having "dislesia." People don't know how to spell it. Or "dyslextic" children.

DR. BLAIR: "Asphasia." (Laughter)

DR. KASS: All types of labels. And this is because the fad and the panaceas I think form such a major portion of the available services.

I think we might find the same thing in mental retardation if the term "mental retardation" and the services were not so widespread. We might, for example, find someone suggesting that Hubert Humphrey's granddaughter has oligophrenia, and they are searching the country for a special school for oligophrenia.

The status term at this time in Texas, as I understand it, is "dyslexia," and if you're anyone at all you must have at least one child with dyslexia. Is that true?

DR. WOLFE: That's essentially correct.

DR. KASS: I think in this field a lot of our tradition is centered about what Dr. Smigel called the European solo professional. We have certainly a number of Europeans who have worked out methods and procedures in this area, and we look to these as our solo professionals.

In addition, I think we have made a great deal of our intuitive geniuses in this field. We put our genius up on the platform in the foreground, and we say, "Show us what you can do. Strut your stuff. We'll watch you, and we'll thereby learn the secret. We'll learn what to do."

So many of our services, the available services, are few and far between, and many of these form the very sort of professional service which we decry.

We give a lot of lip service to interdisciplinary services, interdisciplinary cooperation. We brag about our multi-disciplinary approach. We call in all of these specialists. We listen to them. But I fear in many cases we are merely bringing our individual professional idiosyncracies with us. And, depending upon the group leader, the group dynamics, whichever philosophy or approach prevails depends on who is the strongest, who is the one who leads the group.

I like to caricature or characterize an interdisciplinary team-- This is exaggerated, to be sure, but I feel in many cases we are merely putting on an act in our interdisciplinary team.

Medicine I feel is "prestige happy." And we cater to this.

Psychology is "test happy." They use the battery of tests with which they are comfortable, and they interpret within the jargon of these test results.

Social workers are "gossipy." They like to fill us in with all of the environmental information, whether or not it may be relevant.

Speech therapists, occupational therapists, physical therapists I feel are "copy-cats." They like to think they are closely allied too, they identify with, the medical profession, so they like to use many of the same procedures.

Teachers I feel are "child-happy." They love to tell us all about children. And I think they do a lot of free associating on experiences and on what happens to children and to them, the interaction. Much of what they have to offer is irrelevant.

And special educators -- well, --

DR. KIRK: Careful! (Laughter)

DR. CASS: -- take your pick. Some of us are "label-happy," and some of us are "defensive."

And then the fourth question, one which I hope you will have time to get to -- I hope we won't spend so much time on the definition that we won't get to this -- is this: What is the need for personnel, and how do we train them?

Actually, I think one of the responsibilities of my office at the Office of Education should be to determine the need, and the responsibility of the university training programs should be to determine and to work out ways of training personnel.

Trying to get an idea of the need for such personnel is very difficult and is closely tied with the definition and incidence of these children.

We are all well aware of the controversy and the wide range here, the range of numbers of children. I should hope that in our determination of the need for personnel that we wouldn't be so narrow that we leave out a number of children for whom then will grow up another group of pressure, of lobbyists, pressure groups, another whole set of meetings to determine how many of these children there are and whether they fit within special education.

I also would hope that we are not so broad that we cannot spell out the marketable skills, the services which will be meaningful for the children whom we want to serve.

So the personnel training programs have to I think consider at least five factors:

One is the core of courses, the basic foundation, the basic knowledges. This was something that my panel of experts discussed a great deal, and, in fact, suggested such a conference as this to work more definitively on core concept.

This is true not only for learning disabilities but for multiple handicaps.

The question was raised: Is this just a matter of taking the curriculum for education of the blind, the curriculum for education of the deaf, the curriculum for the education of the mentally retarded and sort of putting these all together in one big curriculum, one which takes longer to go through? Or is there a way of combining and getting a core set of courses?

A second issue has to do with practicum experiences. That is, what kind of field experiences, internships, will the students have.

I have found in my visits to university training programs that these practicum experiences vary a great deal, take in public school work to clinic work. And the clinics also are varied.

There are speech clinics which are used, remedial reading clinics, psycho-educational clinics, psychological clinics, and so on.

Actually, I think for learning disabilities this is probably one of the main factors, one of the very important factors, in the education of personnel.

Third, I think an important issue is job description. Again closely tied in with definition, incidence, and need for personnel is the need for defining the qualities and the skill the technical skills or the professional skills, which will make these personnel marketable and useful in the education of children.

I found in my contact with university teacher training and students that there is a great deal of vagueness and insecurity about job description. It seems very difficult to pin individuals down, and graduate students often come up with the weak response of, "Well, we're just graduate students."

However, as I travel around, I am much heartened and feel very optimistic in the sense that I think the graduate student in the areas of learning disabilities in multiple handicaps today feel very much a part of the growth of the profession and are beginning to feel a responsibility in helping to set forth the job description qualifications and skills.

A fourth issue I feel is very important is recruitment. Unfortunately, our Federal funds are not being spent for recruitment specifically, only secondarily in however the universities themselves want to recruit. With spending some funds for junior and senior year traineeships, I think perhaps more work will be done in recruitment.

But we certainly have inherited in learning disabilities a great many "retreads" -- you all know that term -- a great many individuals coming from various fields who take some additional training and enter the field.

I feel we have done very little in the matter of recruitment at the high school and college level.

Finally, an issue is the evaluation of the training programs. In other words, as Dr. Kirk used to say in the courses I took, the proof of the pudding is in the eating.

And it seems to me that one of the very big issues is: What are the effects of the training programs? Do these people have skills which are peculiarly theirs? Do they add to the educational team?

One of the very best ways to do this is individual soul-searching, of course, which I think each university goes through. The university personnel I'm sure go through their own evaluation, evaluation of their own program.

But another important part of this is the evaluations and judgments which we can receive from consultants. I really think that we don't use our experts -- we don't use consultants -- to the fullest degree.

From personal experience I think this was brought to my attention most forcibly with my first experience with experts at the Office of Education who came to make decisions on the proposals. And the thought occurred to me there that this could very easily become wasted time on the part of the experts if I as the implementer, the Office person, could not carry out the suggestions and ideas in as high a level as they were given.

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In other words, if implications cannot be drawn an implemented from various expert ideas, these individuals are wasting their time.

Probably the best example for us right now would be the example of having a sociologist come in, Dr. Smigel come in, and talk about his work and findings on growth of a profession. It's all very nice and interesting, but unless we really do see some of the implications and can pick and choose what is relevant to our field and our profession, it's just so much mental exercise.

Thank you.

DR. MYKLEBUST: Thank you very much, Corrine.

You just heard another excellent analysis of the problem. I have said to Corrine on several occasions I don't know how a young lady could learn so much in so short a time.

I have been around in some of the agencies in Washington for some years, but it is very rare in my experience to find someone who analyzes the problem as Corrine does. We appreciate it very much.

We will be getting into discussion of your statement of objectives.

Now, for the rest of the time this morning I should like to review then some of the tasks that we have.

We heard Dr. Smigel comment on, it seemed to me, some extremely pertinent questions in regard to professional growth, development, and shifts. In this connection I should like to say that it seems to me that often in this discussion, particularly in learning disabilities, there is a good deal of dealing with the "straw man."

Actually the problem is there. It does exist. But in terms now of Smigel's concept, we all come to it with many different, varying mental sets and concepts. So there does become the problem of dealing with the issues objectively and in a straightforward manner, because it is very difficult for us to get together on just what we want to do.

Now, this raises the question of definition. Definition for what? Sam has been touching on this, and so has Corrine.

I would agree completely with the inference that our first job should be a definition in terms of education, special education, in terms of behavior. It is quite obvious, it seems to me, that a definition for the field of let's say education, meaning special education, is not necessarily going to be the definition that will be accepted by other professional groups.

Now, some people find this very disturbing. I personally do not, because there are many precedents in the sense that medical diagnoses of deafness, of blindness, of crippling conditions, and so on, are not necessarily the ones the educator uses. I think this would be true also of mental deficiency.

I am always reminded of the very interesting phenomenon that most idiots are diagnosed by behavioral criteri Yet today I should think it might be safe to assume that many idiots are not diagnosable by the neurologist. He can't find anything wrong with them or even through EEG.

No, we have behavioral criteria which work very well here, and we use them. And, as a matter of fact, in these instances medicine accepts them and goes along with them.

So I think our task is definition for education, and not really to be greatly concerned as to whether such a definition would be generally applicable.

I have made the comment many times that each profession, for some of the reasons Smigel pointed out, has its own criteria for defining phenomena. I think that is the way it is going to be. I don't think they are going to necessarily shift.

I think that, then, as educators, we have every right to establish criteria, to establish a definition which sets up criteria which may or may not be entirely acceptable to other professional groups or organizations.

Now, I feel that Sam and Corrine were to some extent-- And I hope this is reflecting correctly here your feelings. I think there was a bit of a plea involved, and there is for me too, and the plea is along this line: That surely we, representing handicapped children in special education, can rise to the challenge which has come about here.

In a way, then, we face a practical issue in this country, and there is a great need for some action. This need is now I believe so great that unless we can and do rise to the challenge we really stand to lose a great deal for all special education. And only our concern is for the children involved. All of us can go out and make our way whether special education really gets set back or not. That's no problem. The problem is how to effectively meet the challenge so that the area of learning disabilities is to come extent structured -- and it is realized that it is structured -- so that these children are effectively served.

But also, mind you, if we don't, we're in rather great trouble with even our old standards here. I thought Smigel is even a little frightening here, because, you see, you can't assume that the old things will stand. If there is one thing he is saying, it is you can't assume they are standing. These are shifting a great deal.

It seems to me that some revitalization, some basic reconsideration, which I hope comes in tomorrow specifically, like deaf children with learning disabilities that my friends and colleagues in the field of the deaf are so greatly distressed by that it's alarming the whole field of deaf education-- I hope you don't think I'm an alarmist, but I think this is true. You find 25 to 45 per cent of these children being referred to as having other problems. I think there is a similar kind of situation in the area of the blind.

Now, if we structure this area of learning disabilities and then proceed with some implication for these other areas, I think we have done something for the total area of special education, and I mean all the handicapped children.

I'd like to, however, not leave it just at the level of practical issues. As behavioral scientists I really believe we have something to say. As a group of us right here, we wouldn't agree on every dotted "i" and crossed "t" and comma, but, as I will come back to in a moment, I don't think that's important at all. But I think we will soon be agreeing substantially, as many of us do now, that the children we are talking about are not learning by the usual assumptions at least of the psychology of learning for the other groups.

I think that is the implication of Sam's "in-between" group (indicating the blackboard).

Now, we have some six Ph.D. studies specifically on this point. That is, when you do an analysis of how the youngster with this type of dyslexia, this type of dyslexia, this kind of other type of learning disability actually learns, he doesn't learn according to the assumptions we are making for the average child doing controlled studies now, matched pairs, and using verbal learning techniques, and so on. He simply isn't learning by the same processes. He is a different youngster psychologically.

And that's why I agree so completely that we are not talking about these children where if you manipulate the environment and his experiences that's all you need. That's a different child.

I think then in the behavioral science criteria we are on pretty safe ground when we do assume that these children whom I think we must define as children with learning disabilities without other involvements of deafness and so on, are not learning by the usual set of assumptions that we bring to the usual learning situation in a schoolroom. I don't think they are learning this way.

Now, this is what I think becomes the core of your training of people to work with them, et cetera.

There is a different psychology of learning, and I think this is basic to the whole area of learning disabilities.

I think a basic science is developing, to some extent has developed, in this connection.

So that these youngsters then not only warrant identification and rescuing for practical reasons but for the very basic reason that they need help in a sense that a modification of what is expected from them -- that is, through techniques and procedures -- is necessary for them to ever become -- to ever actualize their real potential.

I don't think they are going to actualize their potential unless other than simple manipulation of environment and so on is brought to their programs.

Now, it happens that I think it is safe to assume that the true mentally retarded actualizes his potential in somewhat different ways, that the deaf do, to some extent the hard of hearing, that the blind do by different ways, to some extent the partially sighted. Crippled, depending on what we mean, may or may not -- may not shift the psychology of learning, that is, so that it is different from that assumed from the normal found in terms of normal children.

Now, there are a few other things I believe, getting more to the issues and the practical aspects.

It seems to me, as Sam was expressing, it is necessary to come up with guidelines which do then set limits on whom we wish to have classified in the category of learning disabilities. One of the problems now is that -- and this is exactly what you said, Sam -- that you can include every human being under the rubric of learning disability. Because, remember, the person who doesn't have a learning disability is simply one who hasn't been studied enough -- just like the one who is healthy is only the one who hasn't been studied enough, you see.

So, it is possible, of course, for every human being to be included. Obviously we must set some limitations.

Now, one way to set limitations is to look at what we have. We have the retarded, the sensorially impaired, the emotionally disturbed, the cerebral palsied, now the culturally deprived. We have these categories. And it is quite apparent that we do not all scientifically surely assume that the criteria here are well established.

I think Jo Taylor was indicating that 20/200 is not a good criterion. Not for you as a specialist and clinician, no. But for society it might be much better to leave it there so long as it's something-- It's something that has to be resolved, but something that is working.

I think that if we are going to be looking for something that every one of us doesn't find fault with, it simply doesn't exist. I think we should approach it this way. There is no such thing as an ideal solution. Believe me, there isn't.

This is my tenth year of serving on committees to define learning disabilities. I'm not going to be around to do it much longer. This is one of the most exciting I have ever been on -- this one right here.

It has been tried by interdisciplinary procedures with excellent people. It has been tried in all sorts of cut-down ways. "This person is troublesome; get that person off the committee." I have seen it work. It has been done over and over again.

Now, there is no ideal solution. Either we compromise and say, "No, it isn't going to work in all scientific situations, it isn't going to work in all clinical situations, it doesn't fit every child" -- that's impossible -- unless we do, this conference will come up exactly as all of the others, and that is that we can't agree and there it is.

Now, there is overlap then from the normal to this population. There is overlap from this population to those in the deaf and the blind and so on. There are overlaps.

Now, may I suggest that to start with our problem isn't that. That's tomorrow. That's the multiply-handicapped.

To start with, the problem then seems to be: Can we come to sufficient agreement as to what it is that can operationally be set up as workable to include the dyslexics, other language handicapped children, but also children that can be defined as having non-verbal learning disabilities but are not then part of the other groups per se? They don't classify as mentally deficient, as deaf, as hard of hearing, as blind, as partially sighted, as emotionally disturbed.

Actually, this is, as I see it, the problem we face in definition.

Now, just a few words on approach to it which I have already tried to outline for you in some material I sent to you.

It seems to me that it is possible to say-- Well, I think we are saying -- could I state it this way -- I think we are saying in special education that there are deaf children

I know some people don't like the term. They don't want it at all. I like the term. I think some people are deaf. I think some people are blind. I have had people tell me right along there are no blind people. I think there are. I think there are mentally ill children, and I think there are mentally deficient children.

Now, let me state it like this: that if we are talking about children that simply fit in those other groups -- and if we are, we shouldn't be here at all then; they are taken care of -- and if we are just talking about children that overlap with these, there isn't really an area.

Obviously we are here because we think there is an area. And I think these are not the same children as those that are in the other areas.

So the first task then would be to prove that they don't belong in the other areas.

So you prove they have hearing. You prove they have vision. You prove they have intelligence. You prove they have certain integrity motorically and emotionally.

Now, this we refer to as the integrities that you have to demonstrate if he is going to be shown to have a learning disability which at least does not overlap with the other groups.

We have spent a long time working in ophthalmology trying to come up with a criterion which says, "If he has more than this kind, this extent of visual involvement, it will affect learning."

We have a publication on this coming out in a few months with our ophthalmologist. And, frankly, it says 20/40. It says if he has visual impairment of more than 20/40 it's going to retard him in learning. So that even though he is dyslexic he has two problems.

Now, this has been an attempt, which has covered now over a decade, to try to get criteria in some of these ways quantified, computerized, and so on, so that you have guidelines, we hope, at least for some purposes of education, and in this way begin to set limits for those that obviously overlap and those that do not.

Because there are children with learning disabilities, aren't there, without visual involvements and without these other involvements?

So if we could agree that these youngsters we are talking about are not primarily children who fit into the other categories-- I'm talking about the problems of definition, which is what I chose as an assignment here for myself simply this morning, to try to help clarify, with the excellent discussions we have had, as to what we will start right off with this afternoon.

Now, if we could agree that there are ways to establish that the child hears and sees and has other integrities which are the type then that keep him out of the other groups, then we have said this child doesn't fit in the categories of special education that now exist.

But now we have just defined a normal child. Now we have to, of course, define him as having a deficit of the kind we call a learning deficit.

Then we are faced with: a deficit in learning what?

Well, it has been traditional to say he has a problem in learning, he doesn't learn, if he doesn't achieve academic learning. And that's still the basic one, of course, that everyone is concerned about.

It is very obvious in the clinical sense -- I can really testify to it -- there are many children with excellent verbal integrities that learn beautifully in the academic situation that have very serious non-verbal learning problems which we call social perception problems. These children are inclined towards delinquency and other kinds of difficulties and are a very serious threat to themselves and to other people.

Now, I am saying that we must define the deficit. What is the deficit? And then we have to say how much of a deficit are we looking for in order to call him a learning disability.

Now, we have said he has integrity in basic ways, including intelligence, then, and so on, and taking the criteria we want to establish for this. And then we say also, "But he doesn't learn normally. He has problems in learning."

All right. Learning what? And how much of a deficit in learning does he have?

It seems to me these are questions we face in coming to some definition of the child with a learning disability.

Now, let me state some of the issues that we obviously face.

I think Frank last night was implying, and I was prepared to listen for it-- I was hoping I was getting it straight, Frank, trying to understand. Because I was at a meeting of the National Convention of State Directors of Special Education in the past two weeks, and we were talking about this problem there. And Charlie Watson was there and someone else from California who slips my mind at the moment. And we got into this discussion. And I seemed to sense, Frank, that in California the trend is to include children with learning problems that they consider frankly emotional. This is my understanding.

You will have a good opportunity to talk about this this afternoon, Frank, as all of the rest of you will.

Now, it seems to me this leaves the door open for some very real problems.

Now, we are talking about a child, if he can't read and is emotionally disturbed, with a multiple involvement.

Now, first of all, it seems to me then we need our norm groups. Who are the deaf? Who are the hard of hearing? Who are the blind? Who are the partially sighted? Who are the crippled? Who are the emotionally disturbed? And then we add: Who are the learning disabilities. This becomes the norm groups.

From this, then, we-- And I say right away, in terms of clinical experience we have all had a great deal of, that a child with a 70 IQ who has been deaf from birth is not the same child as the 70 IQ with normal hearing. You don't just add these up and come up with the same figures.

I learned this the hard way, making some very serious mistakes as a psychologist in a State program for over a decade very serious mistakes.

This deaf child with a 70 IQ has much more of a problem than a normally hearing child with a 70 IQ.

We are going to have to come up here-- I don't know how to do this. But certainly he doesn't rate at a 70 IQ for many purposes, not when he is also deaf from early life.

Now, we have the norm groups. We still have the multiple-handicapped criteria, which maybe have to be evolved for a number of areas. But one question that we face is: Can we agree on a group of learning disability children who are not emotionally disturbed or do not have other problems either?

Now, does this mean that every State must look at it in exactly the same way? Well, now, we are all aware in al the States that no State looks at it exactly like any other State. Every State varies. Here again we have gotten bogged down in many sessions. We are not going to try to tell California what to do. I have been through this.

DR. KIRK: It wouldn't do any good anyway. (Laughter)

DR. MYKLEBUST: Exactly.

Dr. Kirk started off something in this State a year ago on a committee basis that has been followed up with a vengeance during this past year, as you know, Sam. And what I want to say about it is this:

One center in this State says: "But you can't define us this way."

We say, "But, look, we're not trying to define you. You go ahead and do what you want to. You have every right to do what you want to. As a matter of fact, we'll fight for your rights to do what you want to."

But it seems to me that we might, as we do in the deaf and the blind and some of the others, at least get together on some general criteria that for some pretty critical purposes now are needed, that for some pretty critical purposes of guidelines are needed, or I think we are going to bog down into some rather important, maybe serious consequences of setback in various ways.

I realize then that-- Well, I personally feel that we cannot assume that we are going to evolve an ideal solution for any one of us or for any one State or for the nation. That is, I believe, impossible at this time. I don't think it will ever be done. I think these things should be fluid and kept open in various ways.

Our desire here in this conference is rather different. It is that we might-- It's already delimited by not making it interdisciplinary. It was deliberate. It is simply this: Can we for special education agree on some guidelines that might be useful to people other than ourselves in any State anywhere? Is it possible for us to not feel that because we have a commitment to a certain way in which this should be done that it has to be done precisely in the way that I feel or that anyone else feels, but, rather, that we can compromise our total experience -- which, believe me, in this room today is considerable?

We all have a considerable experience to contribute to what is needed. That there is absolutely no question about.

And I think with some taking on of the discussions that we have had then this morning, sort of one at a time, issue by issue, it might be possible for us to come up with a fairly simple delimitation that might be quite workable as a matter of fact.

I said last night it seems to a lot of people today that the time is quite ready for this kind of agreement.

Please do not infer that what I have said this morning is in any sense an attempt to "brain-wash" any of you, to get anyone to think in any particular manner. I have tried to, as I think we all have this morning, to simply state some of the problems and issues that have been suggested and have come to our attention, not only for this conference but over the years through other conferences.

I think, with that, if you have questions about this afternoon we will be glad to have them. Otherwise we will terminate for lunch. And what I want to say-- Do you have a question, Corrine?

DR. KASS: No.

DR. MYKLEBUST: Sam?

DR. KIRK: No questions. I was trying to draw a diagram of what you said, but -- (Laughter)

DR. MYKLEBUST: Good for you.

(Remarks off the record concerning luncheon arrangements.)

DR. MYKLEBUST: We will congregate here again as soon as we can after one o'clock.

(Whereupon, at 12:00 o'clock noon, the luncheon recess was taken.)

AFTERNOON SESSION

1:25 p.m.

DR. MYKLEBUST: I'm sure the others will be in in just a minute. I don't like to start until they come in, but perhaps they won't mind.

So now we do wish to have a discussion from all of you members of the Conference, and I would like someone to lead off.

DR. RIDGWAY: I have a question.

DR. MYKLEBUST: All right, Bob.

DR. RIDGWAY: When Corrine was talking about the objectives of the Conference, she mentioned that it would be helpful if we had a definition that would be beneficial for national purposes. I thought we might benefit from hearing what all was involved in this "national purpose" business.

DR. KASS: The national purpose would have to do with simply getting this term or this group of children within the definition of the law. I don't think the definition itself would be part of the law, or even the interpretation of it, but it would serve to get this into the definition.

MISS TAYLOR: Which is "other health problems."

DR. KASS: Which is under "other health impaired" at this point.

DR. SELZNICK: How was it given that particular designation -- "other health related problems"?

DR. DENO: Somebody thought Sam said "physiological" when he said "psychological."

DR. WOLFE: It was put in there because it couldn't be put anywhere else.

DR. KIRK: When they wrote 88/164, Amendment to 85/926, which was for mentally retarded only, they tried to define what they meant by handicapped children, and they said deaf, blind, and so forth. They had one sentence in there for speech correction, mostly because the speech people said, "Look, we have got to have something designated specifically. You don't just put us under any kind of category." So they said "speech."

So you will find a sentence in there for speech alone, even though the others are deaf, blind, et cetera.

Then they said "crippled." Somebody objected to crippled alone, because what about epileptics and all the other problems we talk about? So they said "crippled, health and other problems that require special education," or something like that.

Am I right?

DR. KASS: "Or other health impaired."

DR. KIRK: "Or other health impaired that require special education."

When we went in to try to write the rules and regulations for it, then people said, "What about the brain-injured kid? What about this? What about learning disabilities? What about it? Are we going to get anything?"

And I met with the lawyers on what this "other health" meant. And, of course, if you meet with lawyers, you might as well sit down and listen about what their interpretation is of the intent of Congress.

And finally I said, "Look, the profession means crippled, but there are some children who are tubercular or epileptic or all kinds. You can't really enumerate all the conditions that require some kind of specialized attention by schools outside of the ordinary."

And then we interpreted learning disabilities or that area because there was no special place for dyslectics or aphasics or something like that. So we said, "Well, we will say that this is health and other special problems."

So it brought it in to the regulations in some way that this could be in, and I think we subsidized four training programs that year and some research.

Now, it was put in as an interpretation. Because if you say "brain-injured" it is easier to interpret it that way. We didn't use the term "brain-injured," you see.

Now, it so happens that somebody comes in with a problem in aphasia, to do something with aphasics, and then the question is: Should it be under the section of speech or the section on crippled children and related problems?

DR. KASS: This is exactly the problem we run into.

DR. KIRK: All the time. So I say it depends on who puts it in. If it is primarily a speech pathologist that puts in the request for speech, have it under the speech people. If it is from an educator doing work in remedial work, we will put it under this other problem. So it is that loose.

Now, the looseness of the law then causes a lot of difficulties, and people have tried to introduce -- with deaf, blind, crippled -- learning disabilities or something like that. It has so far never been accepted by Congress, and that's why Morse, you know, quoted me as saying it's physiological and therefore it could come under health and other impaired, so why fool around with another term when we have already got it, you see.

MISS TAYLOR: An interesting sidelight here I would like to bring in is that the Library of Congress has for years had a library for the blind, you know, and there was so much pressure from parents and schools working with children with learning disabilities, and also others, elderly persons, that the bill was revised, and it has become the library for the blind and physically handicapped.

And they have immediately considered that because the learning disabilities have a brain dysfunction or neurological problem they are eligible.

So that it is not only in the Office of Education that we have these same problems and interpretations.

DR. MYKLEBUST: Yes.

All right. Any other questions or comments?

DR. RIDGWAY: Are there other phases of what you --

DR. KASS: Did that answer it? I believe I did say legally none of the conditions are defined. It seems to me that we are being asked to define this for national purposes for this reason -- that it is either to be separately listed or to be given some place under other health impairment. I mean to sort of make that legal.

DR. MYKLEBUST: Please check me on this, Corrine, if I am wrong. You know much more about this than I. But it would seem to me one thing that was in mind here too was that it is increasingly difficult for your panels to appraise requests on a national basis. So I think one of the national purposes would be that it might serve as a guideline for government agencies, in this case mainly the Office of Education, for purposes of appraising requests and programs.

Would that be a fair statement?

DR. KASS: Yes.

DR. BLAIR: Can we start to work on the definition now?

DR. MYKLEBUST: Sure. Go ahead, Frank.

DR. BLAIR: Two or three of us I guess here were at the conference at Kansas last fall and went through some of these same experiences. I guess we learned something from it. Or did we? But we found really we weren't accomplishing very much until the very last hour of the two-day conference.

So it suggested to us that we should next time, if it should happen, go right to bat and try to pin down this definition.

Some of us were talking at lunch about how we might approach this, and it seems that if one looks at several definitions which now exist we see common elements that run through them.

It seems likely that we shouldn't bother trying to repeat the work of other committees necessarily but to build on what we have. And it shouldn't take us too long to come up with something.

I have just been jotting down here, as we were talking, four points that I think run through some of these definitions.

The first one would be we are talking about youngsters with normal IQ or above.

Second, we are talking about children with learning and/or behavioral manifestations of a particular type or types.

Third, that these are deviations resulting from certain --

DR. KIRK: What was the second one?

DR. BLAIR: The second one was we are talking about learning and/or behavioral manifestations of various types.

Third, we are concerned here that these manifestations derived from deviations or dysfunctions of the central nervous system.

And the fourth would be that these manifestations in learning and behavior do not primarily result from sensory defects, generalized retardation, or emotional disturbance.

Now, there may be possibly a fifth common point, maybe a sixth, even, but it seems to me these are the four that I see running through most of the definitions that we have.

I think that beyond this I would say perhaps problems arising in terms of what specifically are the manifestations we are talking about. What are the learning and behavioral manifestations? And then how do we refer to these? In other words, what terminologies do we use? What terminologies do we avoid in order to bring about communication and in order to avoid emotional overtones that I think so often have interrupted or disrupted our work?

DR. MYKLEBUST: All right.

DR. CHALFANT: I have something to add to the remarks. I did an analysis of the definitions and some of the characteristics. Some of the terms concerning the behavioral manifestations or problems are listed, such as disorders in one or more of the processes of thinking, conceptualization, learning, memory, speech, language, attention, perception, emotional behavior, neuromuscular motor coordination, reading, writing, arithmetic, discrepancies between intellectual achievement potential and achievement level.

Now, when you look at a lot of the characteristics that are included in the various definitions, many of these things could be considered as disorders of central processes as one method of classification or grouping the kind of learning or behavioral disorders.

DR. MYKLEBUST: All right. Let's go right on here. Who else is ready? Bill? Harrie? Is anybody else ready?

DR. SELZNICK: I'm just asking myself a question on number one, normal IQ.

DR. BLAIR: Or above.

DR. SELZNICK: Or above. I wonder if we are not falling into the trap of the past where we are assigning value to an imperfect instrument in assessing youngsters and their suggested learning potential.

I think we ought to relate to what is our specific assignment. And if it is educational, are the tools that we are using to help locate children sufficiently definitive for the purposes for which we are using them?

I go back to what Sam put on the board when he talked about the change in scores identified in certain specific children. And yet we used an instrument to which we assigned what we thought were true values, and yet we found they weren't true values and may have resulted in mislocation of children. I wouldn't say that that happened in this case because the children did obtain release on native abilities.

I think we go back to saying: What should schools do for children? I think that schools have a responsibility to organize a variety of learning opportunities. And rather than to specifically pinpoint an IQ as a basis for location of children, we use that as one of the means for determining the program from which a child can benefit along with other means, and then readjust the child in a location from which he can benefit at that point in his development, rather than assigning true values.

I think we have gotten into traps from which we have never escaped.

DR. BLAIR: Harrie, I think this is what I meant when I said let's avoid the use of terms emotionally-laden. I didn't mean IQ. I meant intellectual potential. And if this is what is bothersome, we could say normal or above intellectual potential.

This is basic. If there is a beast called learning disabilities, then I would be of the opinion that this is at the heart of it. And I would agree with you in terms of the sacredness of the IQ as a score.

DR. RIDGWAY: Why is No. 1 not covered in No. 4?

DR. BLAIR: Well, I think perhaps this simply is a little more explicit aspect of the definition to point out --

DR. RIDGWAY: You wouldn't think a youngster with IQ of 85 who would not be eligible for most programs of mental retardation --

DR. BLAIR: It seems to me this brings us close to the whole matter of overlap, and I would agree we have these problems. I guess the concern again would be whether there is something discrete here that we can look at, at least in the first instance.

Can we look at something discrete? And then I think this matter does spill over into the business of the overlapping. How far down do you go before you reach the retardate and so on?

MISS TAYLOR: Would you give your fourth point again?

DR. BLAIR: Not related to other major handicaps.

DR. MYKLEBUST: Okay.

MISS TAYLOR: That wasn't the way you worded it before.

DR. BLAIR: No, it isn't. Please don't take this. This is just scribbled out here.

MISS TAYLOR: I think this has to do with what is going on.

DR. BLAIR: I think the hammering out of the language is something that needs to come. I think we have to agree on the --

DR. MYKLEBUST: Okay, Jim.

DR. CHALFANT: In developing any definition, everybody has a number of points they want to include in that definition. I was wondering if it might be helpful just to list on the board the major points that everyone feels should be in a definition. Then we can very quickly identify where there is agreement and then focus on those areas where there might be some differences of opinion.

DR. MYKLEBUST: Do you like this approach? Shall we have Jim take the slate and everyone put in what they think should be in it and see what we come up with? Shall we try that?

DR. BLAIR: I think we should.

DR. MYKLEBUST: All right, Jim. Why don't we see what we can do with this?

DR. DENO: Before we start, it seems to me in all the talking --

DR. CHALFANT: I can start off with --

DR. MYKLEBUST: Just a moment here. Now, Evelyn, go ahead.

DR. DENO: Nobody specifically mentioned something which I guess we take for granted. Maybe it's in the definition of disorder. But you mentioned it about assumptions about the psychological learning principles or something like this.

But actually the first criterion here is that this youngster is not learning by the assumptions of a reasonable, regular program. Now this is what is emerges.

DR. MYKLEBUST: That's right.

DR. DENO: That may not be real critical in what is needed in Washington. And partly what gets needed in Washington is by virtue of the fact that we haven't historically defined all these handicaps medically and as health kinds of problems.

Now we are switching over onto a track where we are quite specifically even by the terminology we are using casting it in an educational frame of reference.

And I am very empathic with Harrie here on this point, because the educator can't exclude any kids. And we have this tendency to write exclusive definitions so that they fit the historical patterns of medical definitions, and I know we aren't going to get around this.

We have to somehow reconcile this and deal with it, but it is kind of central in our problem, and maybe that should be right at the top where, first of all, we are dealing with children whose needs cannot be met by the assumptions of the standard program, and that carries a lot of implications.

DR. MYKLEBUST: Yes.

DR. DENO: Because this can change over time. Our regular program sets up certain kinds of expectancies and demands now simply because of the way information is presented or something.

Given some change in the mechanics of this, this has got to be sliding here.

DR. MYKLEBUST: Yes. And it is possible I should think that this could be made one of these -- that these assumptions here must be shifted.

Why don't you try to formulate that? I should think that would be very useful in the setting that you are going to set up here. It might even be a preamble. I don't know.

But probably all of us would want this. I'm just guessing. Perhaps all of us would like to have this kind of statement where we make the assumption these youngsters do need other than regular classroom kind of teaching, and so on.

DR. DENO: Maybe, as you say, that can be a preamble that sort of states to us in an educational frame of reference this is what constitutes disorder and atypicality.

DR. MYKLEBUST: Could we keep in mind that there is a real possibility that we will need some preamble to state even what the definition is aiming at, what we hope that it might achieve. And I think this could be included in that if we want to do this.

Anything else? Shall we let Jim get started?

MISS TAYLOR: I have another point.

DR. MYKLEBUST: All right, Jo.

MISS TAYLOR: I'd like to go back to the point about normal intellectual potential or above. It seems to me that this is taken care of in the fourth point and that we must recognize that there may be some persons of below average who also have, due to other causes, a learning disability.

If you put in the definition of children with learning disability this statement that you start with, you are then not putting yourself in a position of defining the child with the learning disability.

DR. MYKLEBUST: Well, let's see where we are here. Go ahead, Phil.

DR. HATLEN: I was going to say: Have you really changed these four points or what you are aiming at if you eliminate 1 and 4?

MISS TAYLOR: I think you have to have 1 and 4, because this is indicating that the learning problems are not due to the other handicaps.

I mean there are learning problems or learning disabilities due to deafness or something of this sort, but this is not the type of disability we are speaking of in this definition.

DR. MYKLEBUST: That's correct.

DR. HATLEN: Yes.

DR. MYKLEBUST: You know, I don't think we are together. My point 4 doesn't jibe with what you are saying here at all. So I took it down wrong or something.

If we are going to discuss these points, I think we should get them up there on the board. I don't think we are talking about the same thing.

DR. BLAIR: Good point.

DR. MYKLEBUST: Well, if it's all right, then, let's see what-- If we are going to take these points up -- which may be a little bit premature; I'm not sure -- let's put up what we have here if we are going to talk about it.

DR. KIRK: What they have really said, Jim, on No. 1 is that learning disability is assumed to have normal or potentially normal intelligence and intact sensory and motor abilities. I mean that's stating it.

DR. MYKLEBUST: That's correct.

DR. KIRK: Intact.

DR. SELZNICK: Would you say "intact" or "minimally affected"?

DR. KIRK: Or say "minimally affected sensory."

DR. MYKLEBUST: Well, the terminology here could be --

DR. KIRK: We are excluding --

DR. BLAIR: I'd like to suggest I think hammering out of the language is secondary gere.

DR. MYKLEBUST: Yes. The term "intact" has advantages, and so on. You define what you mean by "intact" then.

DR. BLAIR: I think it's the substance we are after at the moment.

DR. MYKLEBUST: Depending on your criteria for those groups.

I do think we perhaps should try to get up what we have.

DR. KIRK: Put "potentially normal intelligence." That gets around that block.

DR. MYKLEBUST: All right.

DR. CHALFANT: Potentially normal intelligence.

Then there was the second point that Frank made concerning behavioral manifestations. How did you word that?

DR. BLAIR: Learning and/or behavioral manifestations.

DR. MYKLEBUST: Does anyone care to comment while this is going on here?

DR. FLIEGLER: If I might suggest, Mike, perhaps to make it a little simpler -- and I'm not trying to divert the group --

DR. MYKLEBUST: Go ahead.

DR. FLIEGLER: I am suggesting what Jim read and what Sam talked about may very well be our initial cue, and that is attempting to describe these youngsters, who they are and attributes they have and attributes we would assume that they do not have to some degree, rather than -- and this is what Evelyn was getting at -- a definition of being exclusive.

It may well be if we describe the youngsters as we see them in terms of certain attributes, our definition may then fall in line. I don't know.

DR. MYKLEBUST: Don't you think this is descriptive, Lou? You're saying what they ought to have.

DR. FLIEGLER: Well, No. 2, you see-- 1 is --

DR. CHALFANT: This could be broken down.

DR. MYKLEBUST: That No. 2 is difficult. That would have to be broken down a good deal.

DR. FLIEGLER: Right.

DR. MYKLEBUST: Yes. All right. I see what you mean.

DR. FLIEGLER: I didn't mean to interrupt you.

DR. CHALFANT: Oh, no.

DR. FLIEGLER: I think the criteria which have been established here certainly will have to have qualifying verbiage.

DR. MYKLEBUST: That's right. In this initial kind of discussion period here, perhaps if we do bring in some of the things other committees have done, it might be a little helpful.

For example, an attempt was made long ago to take No. 2 and describe these children by behavioral characteristic and I am positive we will never get anywhere with it. It has been done. It has been tried. You can't get any agreement about it. It overlaps with mental illness and all sorts of things.

So to say that he is perseverative, distractible, et cetera, simply does not come out at all. Other committees have done it, tried it, even written it up.

Now, some of these children do have such manifestations. Many of them don't, as I am sure we all know. So it isn't really definitive.

I don't think that's quite what Frank had in mind up here.

DR. WOLFE: You really mean deficits, don't you, rather than manifestations?

DR. BLAIR: It seems to me they are manifestations.

DR. WOLFE: You could have positive things --

DR. BLAIR: Manifestation is that which shows itself in a child. That's all.

DR. WOLFE: That's true. But this is true in all --

DR. MYKLEBUST: Excuse me. Jim, go ahead.

DR. CHALFANT: If you have a deficiency in your central processes, this would be reflected then in academic learning or in behavior in some way. So it is really the difference between process and product. With deficient central processes, therefore, the product would be inability to learn academically and behavioral manifestations.

DR. BLAIR: Again I think we are concerned about our language at the moment, and I don't know that we should be. I guess we have to communicate, but at the same time --

DR. MYKLEBUST: Yes.

DR. BLAIR: The third one, Jim, was dysfunctions -- maybe we should add either demonstrable or presumed dysfunctions -- of the central nervous system.

DR. CHALFANT: Which?

DR. BLAIR: Both.

DR. CHALFANT: All right.

DR. BLAIR: I think Dr. Myklebust's paper describes this very well.

DR. SELZNICK: Then we have to ask ourselves: Who is going to identify this dysfunction, and are we assigning the responsibility or a role in the selection process to a nother discipline, the neurologist, for example? Isn't that taking it out of the realm of education?

DR. MYKLEBUST: Well, I will simply say at this point it isn't what I mean at all by taking it out of education. But what do the rest of you think? It wouldn't be what I mean, Harrie, no.

DR. SELZNICK: It has to be said in such manner that the neurologist doesn't say, "Well, even the educators are telling me this is the area in which I should have primary responsibility."

DR. MYKLEBUST: That's right. This has to be avoided

I agree completely.

DR. RIDGWAY: Perhaps the fifth or sixth points up here will get at what is meant by No. 3 in another way that won't bring in this point.

DR. MYKLEBUST: Yes.

DR. CHALFANT: Maybe we should just list them.

DR. MYKLEBUST: Go ahead.

DR. CHALFANT: Then we can talk about it.

DR. MYKLEBUST: Good idea. Let's do it.

DR. CHALFANT: The next one was "not sensory deprivation."

DR. BLAIR: Not primarily resulting from.

DR. CHALFANT: This is the negative component then. Are we going to call this sensory involvement?

DR. BLAIR: I don't think it matters at this point.

DR. CHALFANT: Not primarily sensory problems then.

DR. RIDGWAY: There is another part to that.

DR. BLAIR: Generalized retardation and emotional disturbance.

DR. CHALFANT: Yes.

DR. HEWETT: It's assumed in this approach that all exceptional children have learning disorders, but there is a group that have learning disabilities that have a neurological base, and everybody else who has a learning disorder can be placed in some other existing category? This is the assumption in all this?

DR. MYKLEBUST: Yes, I would think that's quite basic to the discussion as I understand it, Frank. As Sam said, it could be genetic, neurochemical or biochemical or anything. It's not brain damage and neurological in that sense as I think of it.

DR. CHALFANT: Do you want to put in instructional or cultural factors with the rest of this or not?

DR. BLAIR: Well, possibly you could add cultural.

DR. HEWETT: Deprivational really. The kid hasn't been in school.

DR. RIDGWAY: Isn't this implied in all of the areas of special education -- I mean as written into the law as you were quoting it?

DR. MYKLEBUST: I'm just reacting here. I want everyone else to react. It is my opinion that that is true, that you don't have to spell that out here. It does assume opportunity. It is another one of the assumptions, Frank. It assumes opportunity for learning.

DR. RIDGWAY: That he hasn't been locked up in a closet someplace or chained to a bedpost.

DR. MYKLEBUST: That's right -- which is a different problem on this assumption all the way.

DR. CHALFANT: Then there are --

DR. KIRK: When you say that he has a behavioral manifestation, that he has to have some aberration of behavior, and then you exclude it in No. 4 when you put emotional disturbance. They contradict each other.

DR. BLAIR: Only if --

DR. KIRK: In one place you say behavior manifestation. In the other one you say emotional disturbance, which is a behavioral manifestation.

DR. HEWETT: So is retardation a behavioral manifestation. Isn't it a behavioral manifestation?

DR. KIRK: In a sense, yes.

DR. MYKLEBUST: The terminology is overlapping here and would have to be worked out. I think this could be interpreted as inconsistent.

DR. HEWETT: What you mean in No. 2 is somehow we can get some evidence it exists. We can see something or measure something.

DR. MYKLEBUST: I would think that's what you mean, Frank.

DR. BLAIR: Well, I think this is really one of the major problems of defining it -- is this overlap, presumed or real, between emotional disturbance and certain of these behavioral manifestations that you indicate, Mike, quite accurately may occur with brain injury and so on, and it seems to me we have to include in this some of these behaviors that we see in children that, of course, may stand in the way learning.

Now, maybe on that basis we could eliminate it and say this behavior they have, this distractibility, and so on, we see in many of these, stands in the way of learning as Strauss said many years ago.

DR. KASS: Couldn't we call it performance manifestations then to make it more --

DR. BLAIR: Possibly this would be less confusing.

DR. MYKLEBUST: That's a real help, I think. I think we are getting to what Bill said, too. I really think we are talking about what he doesn't learn. It's deficits I think. That's performance, you see.

DR. RIDGWAY: You mentioned that in one of the points you had, Jim, so if you put yours up there you might make that clear.

DR. MYKLEBUST: Go ahead.

DR. CHALFANT: The point I raised? I think that it's deficit in one or more of the central processes (writing as No. 5 on the board).

DR. KASS: Isn't that the same as No. 3?

DR. MYKLEBUST: Somebody has sort of lost you here, Jim. We don't know what you mean. Will you spell it out for us?

DR. CHALFANT: The central nervous system, brain, brain stem and spinal column. If you have a lesion you may have paralysis. By "central process," this would be in the brain proper such as revisualization, auditory fusion.

The central process, you know, is not a function of the brain stem or the spinal column. It's what goes --

DR. SELZNICK: I'm afraid of that.

DR. BLAIR: I would tend to include those under No. 2, Jim, what you have been stating. I think there is --

DR. CHALFANT: Yes, this would also fit under here.

DR. BLAIR: I think on the face of it, No. 3 and No. 5 appear to be identical.

DR. RIDGWAY: If we throw all our ideas in, we're going to find lots of things that are identical. Then you can pull them out.

DR. KIRK: Let's list them down.

DR. CHALFANT: Another idea that goes along with this in a lot of definitions is the discrepancy concept. You have the deficit, one or more-- It's sort of implied here, but Gallagher defines it in terms of developmental imbalances. Dr. Kirk has a definition of discrepancies in functioning.

DR. SELZNICK: What about disorientation in an educational environment?

DR. CHALFANT: What was that?

DR. SELZNICK: Disorientation.

DR. KIRK: What Miss Deno was talking about, maladaptation to ordinary educational environment. They can't learn.

DR. SELZNICK: In the educational environment. That's not saying it exactly, but it's the basic front.

(Reporter's note: Point No. 6 listed on the board as "Disorientation in the Educational Environment.")

DR. MYKLEBUST: Bill?

DR. WOLFE: I don't know how to say this, and I'm not being facetious when I do say it, but I have read a number of definitions, and I am interested to find out what your reaction is to this. Where does poor teaching fit into this thing?

DR. MYKLEBUST: Well, could I --

DR. HEWETT: It doesn't, you see.

DR. WOLFE: I think this is basic, so very basic.

DR. HEWETT: This whole definition says it is the child failure.

DR. WOLFE: That's right.

DR. HEWETT: This is one of the critical issues.

DR. WOLFE: I would guess there are more kids labeled learning disabilities who are resultants of poor teaching than there are children who are resultants of this we are putting on the board.

DR. HEWETT: Don't you think once a teacher can get off the hook with a definition like this, they are not going to be as concerned with teaching if they can say, "There's something wrong with the kid's brain; it's not my problem"?

This is what IQ scores have done. They have stood in our way. And this is exactly what this definition is going to do with some teachers.

DR. CHALFANT: Do you do something different with a kid like this than you do with a kid that doesn't --

DR. WOLFE: And along with that, in the very same breath, this is not a cultural thing in the sense that we use "disadvantaged" and the like, but I'm thinking about the child who is from a high socioeconomic home but who is quite disadvantaged educationally.

DR. MYKLEBUST: We all know these, but --

DR. WOLFE: Surely we do. But are we recognizing them in the definition?

DR. MYKLEBUST: No, it's entirely the intention as far as my comments are concerned to exclude them. You're talking about problems in the whole educational system.

DR. WOLFE: I indeed am.

DR. HEWETT: If we compound them, if they are compounded with something that is supposed to bring clarification

DR. MYKLEBUST: You might view it that way. I think the whole assumption here is though that there is a child with a learning problem that is not the teacher's and not the culture's basically, and so on.

And this other problem you are concerned about

I don't think is the one that we are facing now, not nationally or locally or in State legislatures, or so on.

I think we have got to worry about poor teachers, ladies and gentlemen, believe me, but I don't think it's here. I think this is quite a different issue.

We are talking about handicapped children, not handicapped teachers.

Now, I am just trying to keep us on something that may be resolvable. If we can avoid the issue of what is wrong with the school system-- Believe me, it has been tried a lot of times with committees, and this won't work.

MISS TAYLOR: Why couldn't we put it there where we say "do not arise from" and put "sensory, educational or cultural deprivation"? That eliminates those other things that might be confused with this.

DR. MYKLEBUST: I thought this all would be in the preamble, all said very clearly, that we are not talking about these children. I thought that would be stated very clearly.

DR. RIDGWAY: This is taken care of anyway in No. 5, because if a youngster does not read but has no problems with his central processes, then this is not a learning disability case.

If the youngster can do all of the things that are implied in No. 5, then you have got a teaching problem rather than a problem for special education.

DR. HEWETT: In both 4 and 5 there is a colossal margin for error in terms of deciding when we can rule out thi and that. This is the problem.

It sounds kind of neat when we just put it down. Bu do you realize the margin for error in deciding when a child is not a motivational problem?

DR. MYKLEBUST: What is the margin for deciding a child is mentally retarded, deaf, or blind?

DR. HEWETT: I'm talking about mostly emotional disturbance and motivation.

DR. MYKLEBUST: In emotional disturbance there is a bit more of a problem I would concede.

DR. HEWETT: I would say there is no way you ever rule out emotional disturbance and motivational problems.

DR. MYKLEBUST: I thought this was your position. I think there are people who might have another position, in that you can. I would be one of them.

I think our clinical judgments on these things can be very accurate. Clinical judgment of various other people can be very accurate. So I wouldn't take the position that is hopeless.

DR. BLAIR: I would agree with this point. I think we have enough clinical evidence to suggest we have a population we can point to and say, "Here they are, and, by golly, they are not emotionally disturbed primarily."

Now, many of them have certain manifestations that might be considered emotional, but, by God, they are learning disabilities.

MISS TAYLOR: For whom is this definition being written?

MR. MYKLEBUST: Office of Education.

MISS TAYLOR: Do you think that throughout the country there are those who will not be confused unless you are pretty specific?

DR. MYKLEBUST: Well, again, I think, you see, we are just raising questions that always are there. Obviously people can mislead and misread. They will do that with anything you do. So we can't be sure everybody is going to understand it exactly.

That's what I mean by "slight progress." After all, if mankind makes any progress at all, it's pretty slight, you know. And if we make a little progress, I think that's helpful.

I again wouldn't take the position that because people are going to misinterpret something we do that therefore it isn't useful.

MISS TAYLOR: No. I'm sorry. I didn't make myself clear. My point is that there may be some who may not be able to differentiate, who are in numerous special education programs around the country.

DR. MYKLEBUST: I simply have to say that of course there are. There are in anything you do.

I see more deaf blind children misgrouped than any one category in ratio of any group I have ever seen. But still we do it every day.

DR. BLAIR: It had been my intention earlier -- for some reason I thought better of it; I don't know why -- to suggest that the Task Force I definition might be a thing that we would look at as a model. It seems to me as we develop this, again, many of the points that we have placed on the board are in this definition. And while I think it would mean some revision, it might be a model we should investigate.

DR. KIRK: Would you remind me of their definition?

DR. MYKLEBUST: Let's have it.

DR. BLAIR: I have it before me. You remember the term they used, "minimal brain dysfunction syndrome."

"The term 'minimal brain dysfunction syndrome' refers to children of near average, average, or above average general intelligence with certain learning or behavioral disabilities ranging from mild to severe which are associated with definitions of function of the central nervous system. These deviations may manifest themselves by various combinations of impairment in perception, conceptualization, language, memory and control of attention, impulse or motor function. Similar symptoms may or may not complicate the problems of children

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with cerebral palsy, epilepsy, mental retardation, blindness, or deafness. These aberrations may arise from genetic variations, biochemical irregularities, perinatal brain insults, or other illnesses or injuries sustained during the years which are critical for the development and maturation of the central nervous system or from unknown causes."

The definition also allows for the possibility that early sensory deprivation could result in central nervous system alternations which may be permanent.

I have felt for some time that this is a good working definition.

DR. KIRK: How does that help me in working with kids

DR. BLAIR: Sam, I don't know it does.

DR. KIRK: This is a good medical approach, but it doesn't help us. And what I was going to say is we can try to go through a delineation of the characteristics of these kids and we are going to get into trouble just like that. Because to me this doesn't help me a single bit, this definition, as a practitioner.

DR. BLAIR: Well, it seems to me --

DR. KIRK: I have been trying to think if we can switch gears a little bit and talk about the remedial end.

I wish I had this formulated, because this would be a different approach than the medical model.

The medical model is to describe the characteristics of the kids. In education we describe the methodology of behavior change.

DR. BLAIR: But I don't think when we define deafness or retardation we at that point are trying to spell out remediation, Sam.

It seems to me at this point we are trying to pinpoint a condition that exists.

DR. DENO: That has been what our problem is.

DR. KIRK: That's our problem.

MISS TAYLOR: That's what we are fighting.

DR. KIRK: I'd like to use the term some way or other in the definition of "remediable deficits." There are some deficits that are irremediable that we know of at this point.

Remediable deficits. If we can gear our definition to what we can do these kids, it would be more educational than the medical model definition which was just read, which to me is of no use. It doesn't tell me how to diagnose a kid. It doesn't tell me how to remediate him. It just gives me a lot of words.

DR. BLAIR: I don't think the definition of deafness does either.

DR. DENO: We are not making any claims for the definition of deafness. We think it's lousy too. What we as educators are trying to do is state in some way which puts us in an appropriate dialogue with everyone the fact that our central concern is with the development of competence in children. And the medical models are sort of oriented to the cure of disease. Okay. If it could be cured medically, the doctor should have done that.

DR. BLAIR: I suspect if I had eliminated the phrase "minimal brain dysfunction syndrome" and had inserted "learning disorders" that this would not appear to be the medical model at all.

DR. DENO: Or if you had left in the word "presumed," because I can --

DR. KIRK: Let me say this which every educator knows. You're talking about deafness definitions. Every educator of the deaf knows that decibel loss doesn't define deafness from an educational point of view.

You correct me, Mike.

We define them in terms of their language development. If they lose their hearing at the age of 12, they are going to be educated differently than the one who lost it at the age of one. So when it comes to the teaching point, the decibel loss isn't the important thing.

If a doctor says he is deaf because he has an 80 decibel loss, I would say that doesn't help me. What would help me is his status of language.

Isn't that right? The language definition is the educational definition really.

DR. DENO: Or residual hearing is functional for learning language in the way most kids learn it.

DR. BLAIR: I agree, but I think when we say, "Here is a deaf child," we communicate something. And we are not at that point.

DR. DENO: That's a fallacy.

DR. KIRK: For educational purposes.

DR. BLAIR: It seems to me at this point we are not trying to write the book on what you do with the kid. At this point we are trying to define the existence of this condition and not for all time answer every remediation problem.

DR. HEWETT: I think Sam's point is so well taken in that he is really confronting us with this most critical problem, as I see it, which is this sort of translatability gap that has existed for too long between what we have said about kids in the world of words and what we have been able to do with them in the world of educational deeds.

And it is this translation that is missing from this. And it may be beyond the scope of a meeting like this or a problem like we are trying to solve, but this is the thing -- the translation.

DR. MYKLEBUST: I think the definition could certainly include what you expected. As a matter of fact, I think committee definitions -- good ones -- do. In the definition that I suggested to you in the material, I stated specifically that in the case of the learning disability child you assume normal outcome.

Now, in this regard he is quite different from most any other handicapped child, by the way.

But in this child, rightly remediated, you do assume he is going to have essentially normal outcome, and this is one of the ways, of course, in which you can characterize this group of children. Because most of them do not remain dependent. Most of them do not continue to be handicapped -- not under proper programs anyway.

So, yes, I think that's right. I think that several things have been said here. Extent of involvement in db. And Sam gave us the example of age of onset. Age of onset is obviously involved in every handicapping condition, and it is involved here. We are going to get them at all ages, so age of onset is a variable.

So is the extent of the involvement, which is true of every handicapping condition. How much is there? And so this is measuring the deficit, and so on. How much involvement is there is pretty important.

But, irrespective of this, I think that it is most logical that we do assume that we are going to have good remedial results in this group. I think this could easily be stated and of course written in.

I suppose I feel that such a statement doesn't identi that very well. You can say this about various children, various conditions.

It would seem to me that in terms of an identification you can't avoid that you have to spell out something if it is not going to be just the same thing as what we already have in the area, as we said this morning.

I think you have to spell out how this child differs from the others. Otherwise I just don't think we have an area.

DR. HEWETT: We're talking about children for whom normalcy would be possible in learning?

DR. MYKLEBUST: Yes.

DR. HEWETT: If there is no question about this, then that's kind of one of the basic assumptions.

DR. MYKLEBUST: That is another assumption, Frank, that I make.

DR. HEWETT: I wasn't aware of this.

DR. MYKLEBUST: Yes, I really do.

DR. BLAIR: It's possible but not always predictable.

DR. MYKLEBUST: Of course not always, the outcome. But that's impossible in any human being to predict.

But the assumption for this population is normal outcome, which is not true of the deaf or the blind or the retarded. To some extent it certainly is true of the emotionally disturbed.

DR. HEWETT: I would think it would be more true of them.

DR. MYKLEBUST: I would too, Frank.

DR. HEWETT: Than this particular --

DR. MYKLEBUST: I also make the assumption, if we could just take a moment more on this, that in the emotionally disturbed, in the real long-time pull -- maybe not when you are starting with a child that is seriously involved -- the psychology of learning is not greatly modified. In other words, if you can break through the emotional condition, he learns essentially like other children learn.

Now, I don't make that assumption here. I think these youngsters who are unable to integrate auditorially, perceive auditorially, visually, et cetera, which I won't try to spell out here anymore now-- There is considerable evidence, and I really mean even lower animal evidence, that might be very important in the basic science, that these youngsters do not learn in the usual way. So they differ from the emotionally disturbed there I think.

(Reporter's note: Point No. 7 on the board is "Remediable Deficits," and Point No. 8 is "Do not learn in the usual way.")

DR. MYKLEBUST (Continuing): There is another way in which they differ from the emotionally disturbed. Remember now I am just talking about the way I see it.

That is, to some extent yet -- I think less than 15 or 20 years ago -- you still make the assumption that you should be very permissive in the environmental manipulation with the emotionally disturbed. Now, you don't have to make that assumption here. As a matter of fact, to some extent you make the opposite assumption -- that you structure and keep certain guidelines pretty definite around this population.

DR. HEWETT: This population?

DR. MYKLEBUST: Yes. So again I think there is a real difference in approach. So I wouldn't think the same approach for these populations would be indicated is what I am saying.

DR. HEWETT: You think that this is passing -- that permissive approach? I don't think that exists anymore.

DR. MYKLEBUST: It certainly has gone a long ways out. That's right. I agree.

DR. HEWETT: I think that is historically true.

DR. MYKLEBUST: I said yes, 15 or 20 years ago it's what we did, isn't it? But certainly today you get them on their feet and ask them to do something.

Bob?

DR. RIDGWAY: The discussion we have been having here about the type of definition we use, the model we use, is precisely the reason I asked the question of Corrine that I did when we started. Because if this is to be a definition that is going to be useful to people, then it seems to me that we can do better by talking about processes than by talking about causes.

DR. MYKLEBUST: Yes.

DR. RIDGWAY: The matter of deficits or the matter of processes rather than a presumed or demonstrable dysfunction of the central nervous system. This I think leaves us really way out in the cold saying it can either be this or not.

DR. MYKLEBUST: Yes, I think --

DR. RIDGWAY: I would rather talk about things that we can demonstrate, and we can demonstrate deficits in processes.

DR. MYKLEBUST: I think the point is well taken. We can easily make this adjustment.

DR. RIDGWAY: I really appreciated Sam's comment here about making this definition one that will be useful to teachers who are thinking about going into the field, useful to university staffs that are thinking about starting programs, useful to public school systems.

DR. MYKLEBUST: That is the intention.

DR. RIDGWAY: Useful to everybody.

DR. MYKLEBUST: That is exactly the idea.

DR. KIRK: I think that's the purpose.

DR. MYKLEBUST: Corrine, do you want to comment now, please?

DR. KASS: Yes. I would agree that we ought to leave out all of the possible neurological terms, such as "central nervous system," and perhaps even "central processes," because when we do this we are in effect saying it does belong under other health impaired because we are tying it right back again to some part of the body, to some of the physical aspects.

I have just been taking down some of the terms and words which I think reflect purely educational terms and which to my mind would justify making this another part of the listing -- learning disabilities.

And these are some of the assumptions that were mentioned. And the remediation idea. Possible normal outcome from the training. Disorientation in educational environments Learning deficits.

And just very roughly I would say children with learning disabilities might be those with deficits in learning which require special techniques and methods. These deficits manifest themselves in difficulties in learning developmental and academic tasks. Taking it down to the pre-school level, learning walking, talking, speaking, and the academic tasks of school.

These children are not retarded, emotionally disturbed. I think we have to keep this in. We have to say these are not --

DR. MYKLEBUST: And have opportunity for learning.

DR. KASS: Yes.

DR. KIRK: Let me draw something on the board.

DR. MYKLEBUST: Sure. Go ahead.

DR. KIRK: To clarify what you are doing here.

(At the blackboard) We are saying in the field of education of the handicapped we have different groups. This group is mentally retarded. We have a program for them. Whether it's good or bad, you know, this is defined. The Government gives money for training teachers. Whether they train them right or not, at least they do it on a practical basis. They give research.

We have another group called blind or visually handicapped.

We have another group called deaf.

We have another group called emotionally disturbed, whatever that means. Can you define that for us, Frank?

DR. HEWETT: I wouldn't try. (Laughter)

DR. KIRK: Now, what we are saying is that we have a kid here that-- I don't want to list all the kinds here. It's just an example. We say that this kid is not deaf. If he were, we'd put him in this program (indicating).

What did I say this was (indicating)?

DR. MYKLEBUST: Blind.

DR. KIRK: He's not blind. Otherwise we'd put him here.

If a kid came to me, I'd try to find out.

He's not mentally retarded. Otherwise I'd put him here.

And he's not emotionally disturbed in the ordinary sense.

But the kid isn't getting along. He isn't developing properly, pre-school level. He has developmental deficits in some areas, talking, walking, speaking, understanding particularly in the communication process.

And so this group is in the middle. But he is not exclusive. So what we have is a group that overlaps some of these.

Now, for some of these kids -- emotionally disturbed -- I may set up the treatment as learning disabilities. I think I can get farther with this kid by training him as I mentioned to you.

Here is a kid that goes to second grade, and then he comes home, and next morning he vomits and he is sick and he can't go to school. And he can't go to school and can't go to school. The pediatrician says there is nothing wrong with his stomach. Nothing there. He can't find anything wrong.

Finally they say this kid is emotionally disturbed. "Send him to a psychiatrist."

Then we test him and find out the kid has an IQ of 140 but hasn't learned a single word in reading.

You make an analysis of him. You find a couple of what I call psychological deficits, whether they are central nervous system involvement or not. After all, everything comes from the brain, so you can make that statement. I don't have any objection to it particularly. It's that we haven't brains enough to find out whether it is biochemical, genetic. We can't tell in these kids. So, whatever they say it is doesn't help me. I can just forget about it, because it isn't doing me any good.

So what I want to find out is what he can do, you know. Is there something here that is inhibiting his ability to read? Then I'll work on this.

So I will say I have found two remedial deficits, and I'm going to set up the remedial program.

Is he emotionally disturbed? For that kid I treat him as learning disabilities. After you teach him to read, he stops vomiting and goes to school and is a little more motivated.

But the point is, as Mike said, let's not spend all our time on this group, the overlapping group, at this time. Let's first try to define this central core group in a sense that isn't overlapping. I mean if we did that first, then I think after we do that we will say, "Of course, this group overlaps with these, and we can't define it because it's up to a professional diagnostician to determine."

I have got some cases here where they have been diagnosed as mentally retarded. But I treat them as learning disabilities. I am finding they are remedial deficits that will make them approach normal. And we make them relatively normal even though somebody has classified them here, even though a professional diagnostician has classified them here.

The remedial method is different for this kid than for this kid (indicating), you see, even though both of them, say, may have an IQ of 65 or 70.

So I think what Mike says may lead us a little further. Can we do this without any problem?

Here's a deaf kid that learned speechreading. Here's another deaf kid that can't. This kid probably has a deficit in the visual representational process of some kind where he can't learn speechreading. There is something perceptually wrong with him. We don't know it. So you can fool around with these and do something here. We know that.

But I think we will save time if we define this group first (indicating). I like to define it in terms of not the medical model, Frank, because I think this is the thing that has caused us a great deal of difficulty, because it doesn't help me as a remedial teacher. It has no bearing on what I want to do.

DR. BLAIR: I'm not convinced this is a medical model as much as --

DR. KIRK: Who was that committee?

DR. BLAIR: I understand --

DR. KIRK: They are all MD's except Myklebust. He didn't attend half the meetings. What are you going to do when you have 15 MD's around? What can the medical group do but set up a medical model? Do you think they're educators?

DR. BLAIR: From an extension of their work which is here, hard work on identifying symptomatology of the children, this goes way beyond the medical as far as I'm concerned.

DR. KIRK: I object to that, because they didn't really define symptomatology in such a way I can deal with it educationally. Just intellectually.

DR. BLAIR: The point you are addressing yourself to, Sam, in terms of identifying this middle area is-- At this point I think we can't be this specific about what you do for the children. I think this is still an area for research and so on. We still don't know all the answers to remediation. We know many answers.

DR. KIRK: Can we make the statement they have remedial psychological deficits?

DR. MYKLEBUST: You wouldn't object?

DR. BLAIR: No, I wouldn't.

DR. KIRK: That properly handled would make the kid approach normal.

DR. BLAIR: What I'm concerned about is whether we are getting too broad in our scope, whether we are going to cloud the issue and whether we are going to really depart from a rather succinct kind of definition. It seems to me this is what we are trying to do.

DR. KIRK: I'm trying to follow Myklebust's lead. Let's not spend our time on these (indicating) --

DR. BLAIR: I agree.

DR. KIRK: -- and let's get a hard core. And I'm adding let's not spend our time trying to find out what is a central nervous system defect. A lot of us know a lot of these kinds of some kind of dysfunction of brain. Exclude those and we might get farther.

And then, if we do this, I think we can qualify this statement with this, this, and this.

DR. BLAIR: I'm wondering what the elimination of central nervous system dysfunction does to our definition. I'm concerned about this.

DR. MYKLEBUST: Let's look at that, Frank. It might not do as much damage to it as it seems. Because you can define this educationally without reference to etiology, can't you? And it is entirely possible that that is the most logical and useful thing to do at this time.

Corrine's beginning statement here takes us into that possibility, doesn't it?

So I would suggest that we might try to see what we have here by elimination if we are ready for it. I think Bob's comment is extremely well taken too. And thank you, Sam, for this clarification again.

I think that we might begin to-- Maybe we shouldn't. Maybe it's premature. But if we did start without any implication for this and see how it comes out, I would be happy to see what we can do with it and describe this child as an entity who isn't blind, doesn't have visual impairment, deafness, and so on, and then I think the crux of what Frank is concerned about will be then where we come up with what he is.

As I indicated this morning, if you just define him as what he isn't, you are just talking about a normal child. So then we have to get into what he is, which does force us to say something about what his deficits are.

DR. KIRK: Right.

DR. MYKLEBUST: And then something about the nature and extent and also some of the prognosis or the outlook, which we are indicating here is very favorable if the youngsters are properly managed.

Shall we try that for a time? We still about half an hour before coffee break. Do you want to try that for a while?

Does everyone feel we are ready to see if we can do this now -- eliminating some of these things that have been confusing in the past?

I want you to know I am compromising. (Laughter) I'll give up the ghost pretty soon. (Laughter)

I'm all for the compromise. Bill?

DR. WOLFE: I'd like to ask a question. Again, this is so very basic.

DR. MYKLEBUST: Go ahead.

DR. WOLFE: I'm asking it somewhat apologetically. Are you suggesting that a "gifted child" if he's not achieving at his intellectual level would have then the wherewithal for this label "learning disability"?

DR. MYKLEBUST: Well, properly measured, I would have to say yes to that when you leave out etiology. Properly measured.

Because, as you know, I feel keenly that this deficit measurement has to be done in a certain way.

DR. WOLFE: I got the idea from reading this material

DR. MYKLEBUST: Yes, if he is gifted and then according to whatever it is you are asking him to learn is not being actualized by certain criteria, then I think he has to be considered a child with a learning disability according to what we are saying.

DR. WOLFE: Fine. Let me go ahead.

DR. MYKLEBUST: May I add that is the way I understand our discussion right now.

Go ahead.

DR. WOLFE: Then are we not over-emphasizing? Because it is my strong belief that 90 per cent of the public school programs in this country are not geared to take care of the gifted child.

DR. MYKLEBUST: Yes. I would think though he --

DR. WOLFE: Therefore, aren't we getting a false measure here then of this particular child when he is not properly challenged, when our public schools are not properly geared to take care of him?

DR. MYKLEBUST: I think we all appreciate very much Bill's question, because, you see, we are faced with now defining an under-achiever versus a youngster with a learning disability.

DR. KIRK: That's the question.

DR. MYKLEBUST: And, of course, you will be right into including everybody if we don't watch this.

DR. WOLFE: Particularly in the gifted bit, because our schools are not doing the job.

DR. MYKLEBUST: We are certainly going to have to do something with it.

DR. KIRK: He is not a learning disability, you see.

DR. MYKLEBUST: Under-achiever.

DR. WOLFE: He is by Mike's definition first, but he isn't when you look at the reality. Right?

DR. KIRK: Bill, I don't know who commented on education in general.

DR. WOLFE: I did.

DR. KIRK: We cannot --

DR. MYKLEBUST: Bill did.

DR. KIRK: We cannot take in the whole educational field.

DR. WOLFE: I realize this. But I think we had better state something here for those people to read, you see, so that we will not pose more problems for them.

DR. MYKLEBUST: But now Bill is concerned about what criteria we are going to use to say he is deficit in learning as a result of a learning disability and not deficit as an under-achiever because he isn't being assimilated properly. And I think we have to consider that.

DR. RIDGWAY: What about No. 5?

DR. MYKLEBUST: And Bob comes up and says, "What about No. 5?" Well, Bob, if we leave something like No. 5 in, as I see it, we begin to protect ourselves. Now, you have to have evidence that he isn't normal and simply not being assimilated, I would think.

Any other comments on that?

Lou?

DR. FLIEGLER: It wasn't a comment. I don't know how you knew I wanted to say something.

DR. SELZNICK: It was in your eye. (Laughter)

DR. FLIEGLER: I'd like to ask a naive question first of those of you who have stated rather positively that you know who these kids are. What are one or two criteria clinically that would characterize this youngster as a learning disability?

DR. KIRK: Are you talking about-- Let's take the most common kind of child who goes into the first grade and second grade and third grade and he isn't learning to read, let's say. Right? Clinically we give him an intelligence test to see if he is normal or potentially normal intelligence. That's step No. 1.

The next step is we would give him a reading test, and we find he is at the bottom of the first grade and he is now eight or nine years old. Now we say there is a discrepancy between his mental development and his educational development.

Now, then, the third step is I want to find the correlates, and I don't mean physiological correlates necessarily. I mean psychological correlates. All clinicians are trying to find out what psychological deficits this kid has that have tended to inhibit his ability to learn under ordinary instruction. I am assuming ordinary instruction.

Now, I may give him a lot of tests or Mike may give him a lot of tests, and I will use his terminology. He talks about auditorization and visualization. Now, we have tests for these. And if we find the kid is very deficient in visualization ability, inability to reproduce visual symbols in sequence, if he is unable to auditorize, discriminate auditorially, even though he can hear, or blend sounds, then I say he has got two disabilities.

Now, then, that tells me that in the remedial program for this kid I had better correct these psychological deficits, and I will attach it to a reading program.

I will teach him to soundblend and teach him to reproduce the Fernald, the phonics system, as an auditorization system.

So I may use these at different stages, but it defines for me the remedial process, hoping with this process I correct his psychological deficits and teach him to read.

Now, that is simple, but I have to look at the correlated psychological deficits, so I tend to define a learning disability as that which has demonstrable psychological symptomatic-- Not brain. Even though I concede it may be there, I can't test it. But I can test his psychological deficits and auditorization and visualization and other things, you see.

Now, if I can demonstrate that this kid has these psychological deficits as correlates, discrepancy between mental chronological development and the other, then I will classify him as a learning disability.

On the other hand, he may be eight or nine years old and I test his mental development and find he is normal. I test his educational development and it is only first-grade.

I try to find some correlated psychological deficit, and I can't find them. He just hasn't been in school. And that's the educationally retarded child Bill Wolfe is talking about, and I would not classify him as a learning disability unless I can find basic psychological-- This is analyzing the symptoms of behavior.

DR. WOLFE: We had better make this clear though.

DR. MYKLEBUST: That's right.

DR. WOLFE: May I react to Lou's question?

DR. KIRK: Excuse the speech.

DR. FLIEGLER: Quite all right. You cleared it up.

DR. MYKLEBUST: Are you through, Lou?

DR. FLIEGLER: Yes.

DR. MYKLEBUST: Bill?

DR. WOLFE: Let me try to rephrase what Sam has said in just a short sentence possibly. Could we not use the two terms "globally involved" and "scatter performance" on the results of individual psychological tests? Would this not be a clue? That is what I am asking.

A person who is globally involved is not the guy we are talking about -- if he is low, that is. The guy though that is scattering in his performance certainly would be a clue, though, would it not?

DR. MYKLEBUST: It would be a clue, yes.

DR. WOLFE: A clue only, yes. Isn't this what we are talking about, Sam, when you ask for something the clinician or the teacher could use in helping her identify this problem?

dr. myklebust; By psychological tests now you mean mental tests?

DR. WOLFE: Mental tests, individual tests.

DR. KIRK: I'm talking about analytical tests.

DR. MYKLEBUST: We would include the whole battery.

DR. WOLFE: I know. But I'm speaking of the individual psychological examinations.

DR. KIRK: It doesn't help me in remediation. It tells me what his level of reading is. But it doesn't help me in remediation. But what I want to do is find out what is wrong with this kid. Why has he been in school three years and hasn't learned? Then I go through correlates.

Maybe he has got a fusion problem. Maybe he has got auditorization problems or visualization problems. Maybe he has some other disability. I want to find it.

If I can't find these-- I mean it's up to the diagnostician to prove that there is something wrong in the developmental process and it is developmental discrepancy. And at the preschool level you cannot tell it. At the school level you can tell it.

DR. BLAIR: Sam, I think if there is any agreement we have I think it is on this point.

DR. KIRK: All of us do the same thing in the symptomatic. We get bogged down when we talk about the hypothalmus and the adrenal cortex.

DR. MYKLEBUST: Now, if I may, there are some who haven't had a chance to get in on this. Sam, you're one. Go ahead, Sam.

DR. ASHCROFT: I just wanted to ask if the kind of problems you have just enumerated in visualization, auditorization, could be subsumed under "cognitive function."

Let me tell you where I am going if your answer is yes.

DR. KIRK: You will have to define "cognitive" for me, because "cognitive" in my terminology is more at the meaning, representational level, and these others are more basic and non-meaningful. The kid has them or doesn't have them.

You can take a kid, you know, and he can't close. He can't put parts together in a hole. So kids have it or don have it, and they develop that way. And this reading is a closure process primarily.

So what do you mean by "cognitive"? Then I will answer your question.

DR. MYKLEBUST: Do you want to go ahead, Sam?

DR. ASHCROFT: Yes. I mean learning.

DR. MYKLEBUST: Why don't you tell us what you had in mind?

DR. ASHCROFT: Well, it is the same model, the discrepancy model, in terms of expectation versus achievement and then discrepancy. And then we in another sense develop hypotheses about the source of the discrepancy. And we rule out for these children instructional things, environmental social factors, emotional factors, sensory factors, and physical factors.

And I would like it if we could wrap it up in something like cognitive functions. But that apparently isn't quite --

DR. MYKLEBUST: I agree with Sam. There's lots of trouble with the term today.

Anything else, Sam?

DR. ASHCROFT: No.

DR. MYKLEBUST: Bill Heller, what do you have to say before coffee break?

DR. HELLER: Sam and I were drawing the same pictures. And I am interested too in defining that core first. In fact, I have the same thing here that he drew.

Also I think on that second point up there the thing that bothers me here that we haven't brought in is the situation which goes to the educational situation that we are talking about. It's something Evelyn mentioned too.

We are defining this in terms of where we are seein the child, and he is functioning in an educational situation.

DR. MYKLEBUST: I don't quite get your point. Is this good or bad?

DR. HELLER: Well, we are talking about deficits and bringing in in the preamble here that we are talking about education. It could be a part of this -- learning and/or behavioral deficits occurring where?

DR. MYKLEBUST: I see. Well, all right.

Now, let's see. Evelyn, did you get through? Do you have anything else right now?

DR. DENO: No. I'm still with the point that you are defining dysfunction in terms of adequate -- having had adequate opportunity to learn.

DR. MYKLEBUST: You don't think you could make such an assumption?

DR. DENO: No, I think that's all right.

DR. MYKLEBUST: Phil?

DR. DENO: But that it should be in here. The child has had adequate opportunity to learn.

DR. MYKLEBUST: Absolutely. It has got to be.

DR. DENO: This isn't necessarily just in school.

DR. MYKLEBUST: If you don't, you have the whole cultural deprivation for which there are entirely different laws and regulations and funds and everything.

Yes, Bill?

DR. HELLER: On No. 7 I would just put in "potentially remedial," because from a teaching standpoint --

DR. MYKLEBUST: Yes.

DR. HELLER: -- if someone gave me a report and said that this is remediable and I didn't remediate it, there may be something outside my teaching ability.

DR. MYKLEBUST: Exactly.

Phil?

DR. HATLEN: Not much right now. I have been drawing diagrams too. And I started out with all children and ended up with a little narrow group in the middle which overlaps in both directions. And it seems to me in very general terms these are simply the kids that don't have any handicap as is now defined but don't operate in regular classrooms, and I don't know that any of this has helped me any further as far as what I am going to do with the child in the classroom.

DR. MYKLEBUST: No, it really isn't intended to. I must stress that the whole process of remediation would be som thing else.

I would think that we can imply remediation here all the way, and so on, but it would seem to me that we are trying to agree on how to identify the child, who this youngster is.

I do think that, should we get too far into the remediational aspects, again it would be quite an impasse. I really think so.

There are things you can do today it is quite obvious. In this State you certify teachers for learning disabilities. We have been doing it for four or five years. And some other States, of course, are very much along the lines of the same procedure.

This assumes that you train these people in certain ways just like it does in the other areas of handicapped children.

I think then could I try to-- I'm not trying to terminate anything, but maybe we are ready for a coffee break. It seems to me that as a group we are saying that we want a description, operational definition, that says something about this child's integrities, what he can do, what he is. That is he is adequate intellectually.

And, of course, as you know, some of us have worried a great deal about what we mean by "adequate intellectually." He is adequate in his sensory functions, his vision, his hearing.

Again, despite the fact that we have years of experience there, there is still a great deal of disagreement about it. And right now in this State we are in the process of writing a whole revised definition of who the hard of hearing child is.

We say he is adequate in vision. All of these things make assumptions which I would think we would probably want to try to get at next, as to what do we mean by these, if he isn't this and this, taking the diagram, what Corrine presented, and some of these, and that he is, however, deficit in certain respects.

It seems to me that that is perhaps where we are yet not very far along in our discussion. We have certainly been referring to it. We perhaps will have to come back to something of that type.

What did you have on deficits, Corrine?

DR. KASS: Oh, not much, because what I wanted to point up was the fact of deficits which require special techniques and methods.

DR. MYKLEBUST: Yes.

DR. KASS: In other words, the requirement of something other than going back and correcting or filling in would be the key.

DR. MYKLEBUST: This might be a good key here to alleviate the need to approach the deficit problem in various details and technical ways, but this then remains to be seen.

Sam?

DR. ASHCROFT: Is there a useful distinction that might be made between discrepancy and deficit? What I am thinking of is, "deficit" implies a lack and to me is less remediable than "discrepancy."

And we really take expectation in terms of the child and then look at some discrepancy between what we could anticipate and what he is producing.

DR. MYKLEBUST: Yes. Well, I think the point is well taken that these terms certainly should be looked at both ways.

I take just a moment to tell you that we did work on the learning quotient now for almost two years. You can measure under-achievement versus potential with considerable scientific accuracy. I would plead that cause. I think we have done it. You can do it. You can show that it is quite meaningful to schools in terms of expectancy age, what he is supposed to be learning and what he is learning as a ratio.

You can quite accurately show that this child has, therefore, a discrepancy -- we have been calling it "deficit" -- a discrepancy between potential for learning and actual learning.

At this point all you have done is to describe under-achievement.

DR. KIRK: Right.

DR. MYKLEBUST: And then from this point on you have to decide by some criterion. It might be by the elimination of what we have said so far today, because that is the only way to avoid it except through etiological terminology it seems to me.

But then if you say that he is not otherwise retarded, sensorially impaired, emotionally disturbed, and so on, then something about processes like Corrine has here may pick it up. Then this would eliminate the regular under-achiever.

Bob, you have something?

DR. BLAIR: I have something started. Do you want to hear it now or after coffee?

DR. MYKLEBUST: Bob is first. Go ahead.

DR. RIDGWAY: Mine was shorter. It seems to me includ ing the things you were talking about and the things we seem to have general agreement on, something like this might come out: That such a child, a child with learning disabilities, has a remedial deficit in one or more of the psychological processes of perception, association, and expression which require educational programming different from that in the typical classroom. These deficits are not primarily sensory, caused by generalized retardation or emotional disturbance.

This in essence is what you were saying.

DR. KIRK: Are not the result of.

DR. RIDGWAY: Yes.

DR. MYKLEBUST: All right. Fine, Bob.

Frank?

DR. BLAIR: Well, it is similar I guess. I haven't quite finished yet. But the term "learning disabilities" refers to children of average or above intellectual potential having adequate environmental and/or educational opportunity who, for reasons not primarily related to sensory disorders, generalized mental retardation, or emotional disturbance, manifest disruptions in essential processes of verbal and/or nonverbal learning.

Such children generally demonstrate a significant discrepancy between expected and actual learning achievement.

The conditions manifest in these children may involve impaired perception-- And then I was going to go on and list a few.

DR. MYKLEBUST: Well, I think this is a good time for a little break. It has been a good hour.

(Whereupon, a recess was taken.)

DR. MYKLEBUST: Now we are ready to go again.

A couple of people were cut off a little bit there by the coffee break. Both Corrine and Jim Chalfant. Corrine, do you want to take it first?

DR. KASS: No.

DR. CHALFANT: I really don't have anything to say no

DR. MYKLEBUST: You have settled down already?

(Laughter)

May I ask you now as a group: Do you want to take whatever time it takes, the next hour or whatever, to get further into the question of extent of involvement, how much discrepancy between potential and learning?

Well, I don't know just where it comes in mostly on our outline up here, but it seems to me that it is possible we have fair agreement on some description that these children ar not so and so, and so on, despite the fact they have good opportunities for learning.

Now, getting to the question of involvement, you know in the past years a child has been considered retarded in his educational achievement if he were one, two, three or more grades below where he was expected to be. In our own efforts we have this much too loose a definition, so we have proceeded to evolve a way in which to appraise this in other terms.

Now, how you appraise the extent of it and what cut-off you take, of course, will give you something as to incidence problems -- how many of these children, how many of what type, and so on.

How do you feel about it? Would you like to take that for a little while?

Bob, did you have a comment on this?

Or do you want to go back to where we were on more of the concept and problem that we are talking about?

DR. FLIEGLER: I would like to firm that up, Mike. I think we have reached a critical stage, and I think we have heard two fine definitions. We may want to change the order a little bit. But there is no doubt -- and I think Sam responded quite accurately -- that certainly Nos. 1, 4, 5, 6 with some change in wording, and 7 are included pretty much, with the crux of the matter being 5. I think this is essential.

There is no area in special education except for perhaps one where we have hung our hat on this.

I think if we could firm up the basic elements, since we have them here, that we would be on the road to success. And we all recognize that certainly we are rushing, but I think we have thought a lot about these things. We have all come here fairly well prepared.

And then, if you don't mind, I think it would be important to move to that discrepancy quotient. Because if you remember this morning we pointed out that much of definition, regardless of the incidence, is based upon some statistical referent, whether we like it or not, and since we are developing this definition for legislators and so on.

And then, hopefully, we would come back -- and we have two definitions which are really very much related -- and see if we can firm it up.

DR. MYKLEBUST: Very good, Lou. Do you suggest we take these one at a time? I see No. 1 there as being repeated in No. 4 under retardation. Not primarily sensory. Or if we say not primarily mental retardation, you have really said No. 1, haven't you?

Would you agree No. 1 is repeated there in No. 4? They both are referring I think to the level of mental ability.

Or you could change No. 4 to say potentially normal intelligence, if you don't want to state it in terms of the negative as not mentally retarded.

And then you said 1, 4, 5, 6 and 7, didn't you, Lou?

DR. FLIEGLER: That's right. These seem to be the basic elements.

DR. MYKLEBUST: Yes. Then it is possible, Jim, that if you want to take this --

DR. KIRK: No. 5, he said.

DR. MYKLEBUST: Yes, but No. 4 too, didn't he? 1, 4, 5, 6, and 7.

All right. Why don't we sort of re-do this? Shall we see where it comes out?

Now, please come in here, folks. What would you say? Shall we leave No. 1 out and state it all under No. 4, what is now No. 4? That might become No. 1, you see.

Bob, tell us what you would do.

DR. RIDGWAY: I would do just as you suggested. Have No. 4 be the primary way to exclude people that are now included in other programs.

DR. MYKLEBUST: Then we can leave out 1, 2, and 3, Jim. Why don't we take them out and start over here and see what we come up with. Okay?

DR. KIRK: Children with learning disabilities are those who do not have primary sensory --

DR. MYKLEBUST: Good, Sam. Put it right up here, Jim.

DR. KIRK: Something like that. We use the exclusio first and say what they aren't, and then what they are.

DR. MYKLEBUST: Good. Now, we need everyone's thinking on this in words now. We are going to see if we can make a statement here, Lou, that will include what you have just indicated.

DR. CHALFANT: Children with learning disabilities are -- ?

DR. KIRK: -- are those who do not have primary deficits in sensory, intellectual, or emotional disturbance. Is that stating it? Or is that too much?

MISS TAYLOR: I don't think that is really stating it. I think we should describe the child and then say that these deficits are not primarily due -- are not due to these things. Then we do not eliminate the possibility that a child who happens to have one of those might also, completely separate from the first-- I mean, that is, your fringe group then may also have a learning deficit.

DR. KIRK: You can state it positively or negatively.

DR. FLIEGLER: Let's put the other one up here. Sam, do you mind?

DR. KIRK: No, there's nothing sacrosanct.

MISS TAYLOR: Let's describe these children -- children who have a deficit in one or more, et cetera.

DR. KIRK: I would say "are those who have had adequate instruction and opportunity and in spite of that who" opportunities, show deficits (discrepancies) in developmental and educational (psychological) processes. . .")

MISS TAYLOR: Are we going to put disorientation in the educational environment, or is that included in the other?

DR. KASS: "Which can be."

MISS TAYLOR: Maybe we could put "show potentially remedial" --

DR. FLIEGLER: We'll change it later. Okay?

DR. MYKLEBUST: Sure. Go ahead and put it up there.

DR. FLIEGLER: Don't worry about antecedents and so on.

DR. KIRK: Which are, through proper remedial methods, remediable. With special remedial measures.

DR. CHALFANT: Responsive to special remedial measures.

DR. KIRK: Can be ameliorated, or something like that. Use the term "amelioration."

DR. KASS: That's too medical.

DR. MYKLEBUST: Say it very simply -- which are remediable through special education.

DR. RIDGWAY: We stated earlier "remedial deficits in these areas."

DR. KASS: "Show remediable deficits." Yes. That would be good.

DR. HATLEN: You added "which require special techniques."

DR. FLIEGLER: Which are remediable through special techniques? All right?

DR. KASS: Which can be alleviated through special techniques.

DR. KIRK: You don't want to use the term "ameliorate"?

DR. KASS: No, because we have "remediable" in there.

DR. MYKLEBUST: He says "ameliorated."

DR. KIRK: You say that's a medical term. I don't think it is.

DR. KASS: I mean, you know --

MISS TAYLOR: And which are not caused by.

DR. KIRK: The result of.

MISS TAYLOR: The result of. That's good.

DR. KASS: Which are not primarily the result of.

MISS TAYLOR: Yes.

DR. KIRK: Sensory, motor, or intellectual deficits.

DR. FLIEGLER: Central, motor, --

MISS TAYLOR: You want "emotional" in there.

DR. KIRK: You don't want "central" there. Sensory.

DR. FLIEGLER: Sensory? I'm sorry.

MISS TAYLOR: "Emotional" you do though.

DR. MYKLEBUST: Yes. Sensory, motor, intellectual,

DR. KIRK: Intellectual or emotional disorders or deficits.

Frank, what did you have in your definition?

DR. BLAIR: I think that's a little awkward. I think it has all the points. I don't think "remediable" belongs at that point. I think it should come in as a final statement perhaps.

What was your question, Sam?

DR. KIRK: Your definition included a lot of those. I wonder what we missed from your definition. That's all.

DR. BLAIR: Not much. I think it's a matter of just language arrangement. I would be happy to repeat it.

DR. KIRK: Go ahead.

DR. BLAIR: The term "learning disabilities" refers to children of average or above intellectual potential having adequate environmental and/or educational opportunity who, for reasons not primarily related to sensory disorders, generalized mental retardation or emotional disturbance, manifest disruptions in essential processes of verbal and/or nonverbal learning.

Is that in there?

DR. RIDGWAY: Yes, developmental and educational processes.

DR. BLAIR: Such children generally demonstrate a significant discrepancy between expected and actual learning achievement. The conditions manifest in these children may involve -- and I have added a few things -- such areas as impaired perception, conceptualization, verbal language development, reading, writing, numerical concepts, spatial orientation, social perception.

Then, to bring in the remedial aspect, I said these disruptions in learning are in most instances remediable when special educational techniques are employed.

DR. WOLFE: I like his. I think it's very good, comprehensive.

DR. BLAIR: I think we can certainly question the listing here I have of the kind of deficits. And then your criticism, Mike, of whether mental retardation should be included too.

DR. MYKLEBUST: Whether you need that statement. The first paragraph Frank reads there to me is a little heavy and a little hard to follow.

DR. BLAIR: It's long.

DR. MYKLEBUST: It's a long one. It sounds like Proust. It's "Prousty." When we studied Proust and compared him with a lot of other people to find out why he was difficult, we found out it was because he wrote as much as 60 and 70 words in a sentence.

Frank, you're "Prousty." (Laughter)

DR. BLAIR: That's the nicest thing that has been said about me all day. (Laughter)

DR. MYKLEBUST: But I agree, Bill. I think this is real progress.

How do you want to proceed now? Do you want to alter what we have, and should we re-do Frank's? Shall we re-do this?

Yes, Jim?

DR. CHALFANT: If I were a Congressman, I would say, "What do you mean by developmental and educational processes?"

DR. MYKLEBUST: Yes.

DR. KIRK: I think what we want is a general definition, and then follow what Jim did in one thing here -- turn around and define the words that were used.

DR. KASS: By all means.

DR. KIRK: In more specific terms.

DR. MYKLEBUST: Yes.

DR. KIRK: I think if we do that-- You can't put everything in a general statement, but you can put a fairly good general statement that I would agree with.

I would take "in spite of" out of there.

DR. WOLFE: Put in "yet."

DR. KIRK: "Who still could not."

DR. WOLFE: "And yet show."

DR. KIRK: Yes -- "and yet show."

DR. BLAIR: Isn't that all one sentence, speaking of Proust?

DR. KIRK: Well, Frank, as I understand it, people like me have to write in short sentences, because they are not smart enough to write 60-word sentences and make sense out of it. Those who can do that really have ability.

We did this in a group here, which is phenomenal. It doesn't make sense, but we did it. (Laughter)

Remember, now, I think this has to be followed as Jim said-- We have to follow to define our terms here used in this definition.

By "remedial deficits" we mean that by special techniques and learning situations the children can be improved, ameliorated, approach normal in these deficits.

By "educational" we mean disabilities such as in reading, writing, arithmetic, spelling, and so forth.

By "developmental" we mean primarily the communication process, perceptual, and the communication process as such, if you include perceptual in the communication process. Because we are talking there of delayed speech, delayed languag delayed perception, inability to see things right, inability to understand things right, inability to operate primarily communication.

DR. MYKLEBUST: But this is a term that today much work is-- It's not negotiable.

DR. KIRK: Communication?

DR. MYKLEBUST: You can't get together on it at all. "Language" you can get somewhere with. If you mean verbal or-

I think there is something here that is indicated. Either say verbal or nonverbal, or language or non-language, or something like this.

Well, I think communication theorists, the psycholinguistics-- There are hundreds of people who get into communication. It is very hard to hold down in any way.

DR. KIRK: Let's spell it out by saying in learning to talk, in learning to --

DR. MYKLEBUST: You can call it language, you see.

DR. KIRK: How about perceptual?

DR. MYKLEBUST: Then you have to use that also. You couldn't use just language, no.

DR. KIRK: Okay. We can use in psychological, developmental, and in visual, perceptual, in language, verbal, nonverbal, whatever you want. But I think in the definition we ought to spell out a little bit what we are talking about that applies to both pre-school and school.

DR. MYKLEBUST: Well, I would agree. I wonder if we could avoid some of these very troublesome terms today. "Perception" is very troublesome to everybody. Everybody gets upset with it, either pro or con.

I don't know quite how we circumvent it, but I do think these are terms today that in legislation and other ways are giving us lots of trouble.

I thought Frank had some followup on his definition that indicated something. What was that? What was it you said?

DR. BLAIR: I did include perception, however -- such areas as impaired perception, conceptualization, verbal language development, reading, writing, numerical concepts, spatial orientation, social perception.

DR. MYKLEBUST: There are many terms there in what Frank just read that I would have to say in my own experience simply aren't negotiable. You can't get it through anywhere. It really includes everything under the sun, conceptualization, perceptual processes.

Now, the way it is being done sometimes is to say you mean it includes conditions commonly referred to as aphasias, dyslexias, and so on. Sometimes that goes in certain situations.

Maybe we don't want them. Call them just verbal.

Then, instead of the perception, conception, and so on, disturbance of-- And this gets into Harrie's term, "disorientation," which is one of the most difficult today, because disorientation in the field of learning disabilities in many ways means people who don't know right from left, can't learn time, and can't learn spatial concepts, disoriented in space and so on.

So this term "disorientation" I would have to say in many circles at least in learning doesn't mean what you mean at all.

DR. SELZNICK: No, I was thinking of maladaptive, inability to handle --

DR. MYKLEBUST: This is what I mean. If we could get away from some of these, we would have I think perhaps in most situations better acceptance.

So I wonder if you get to the nonverbal if you want to say something about these. If we want to list-- I don't know how much we should list either. This is also troublesome. But you could say "such as," which has been done, of course, several times. And then it gives sometimes quite a list, and sometimes they give just a few.

But like time concept is disturbed, and that is usually thought of as nonverbal. I mean it is disturbed in a number. Spatial perception. Right/left orientation. And so on. These are common nonverbal disturbances in this population.

How do you want to proceed here. I think what we are getting at here is how to say this to best say what we mean and not cause too many people to be concerned or rejected just because they don't get what we mean by the terms.

I don't want to jump ahead here now. Do you want us to try to take all of these and write it a little differently for tonight's session? Do you want to terminate a little earlier and some of us work on this and see if we can get something that would work out for tonight?

DR. SELZNICK: Could we get copies of the several suggestions that we could lay alongside?

DR. MYKLEBUST: That's what I was wondering. I don't know whether I can get them duplicated tonight.

DR. BLAIR: Are you saying kind of a subcommittee thing to --

DR. MYKLEBUST: Yes. I was wondering about that.

DR. RIDGWAY: Are you saying that-- I think I hear you saying that we are fairly happy with this definition and now we are talking about amplification --

DR. MYKLEBUST: Yes.

DR. RIDGWAY: -- of the definition.

DR. MYKLEBUST: Yes, taking this and what Frank has presented and putting these together with one definition, of course, and this does assume, Bob, that we feel we should go on to that detail about it now.

It is going to take a little while to write this up I think and get it into a form that might overcome some of the problems that I feel would be very prevalent unless we do watch the language and terms used.

Take the suggestions of all of you. Like Jim says, what do you mean by developmental processes? And so on. And what Sam says. It will be necessary, of course, to have some statement of what we mean after we get this done. I think we perhaps need more of a preamble, a rationale for it.

I don't know. How do you feel about it? Does this sound like a way to proceed?

DR. WOLFE: I think the words "remediable" and "allev ated" in the same statement might be questioned. Leaving out "remediable" and putting in "remediated" for "alleviated" would be much better grammatically.

DR. SELZNICK: What does it mean?

DR. MYKLEBUST: Yes, Phil?

DR. HATLEN: I had trouble reading this, so I rewrote it for my own purpose.

DR. MYKLEBUST: All right. Can you all hear? We are getting some traffic outside.

DR. HATLEN: This is taking this and rewriting it so that I can understand it better myself.

Children with learning disabilities are those who have had adequate learning opportunities, yet indicate remediable deficits in developmental and educational processes. These deficits may be minimized -- or what? -- eliminated or remediated -- through special instructional techniques. Learning disabilities are not primarily the result of sensory, motor, intellectual, or emotional disorders.

That's the same thing as there except that I can read it a little better.

DR. BLAIR: I think we are saying the same things over and over. I think we are beginning to cover the same ground. I wonder if this subcommittee idea wouldn't make sense to expedite things.

The Chairman might appoint a subcommittee that would be willing to go to work on this.

DR. MYKLEBUST: Is that agreeable with everyone? Do you want to proceed that way? How long a time shall we allow here? We're going on towards four o'clock. Could this committee, do you think, have something ready for us by seven-thirty tonight? Do you think you can make it?

(Discussion off the record.)

DR. KIRK: Is the committee going to include, following a generalized statement, some specific delineation of educational, psychological, remedial, some of the words there? Will the committee do that, define those?

DR. MYKLEBUST: I think so, but I'm not sure we'll get it all in. I rather would like everyone to be working at this, but the question is whether we are most efficient and effective this way.

Corrine has something here too that I think an hour or so ago sparked all this that seemed to have some very good sentences in it. I think really the committee should be looking at that in addition. It does have a little of what you just mentioned I think.

What is that, Corrine?

DR. KASS: Children with deficits in learning which require special techniques and methods. These deficits manifest themselves in difficulty in learning processes-- Oh, I just added that. I was saying in learning developmental and academic tasks. But I could say, instead, in learning processes -- period. And then we could define those.

DR. MYKLEBUST: Developmental and academic learning.

Before we proceed, then, I do want to raise this question again. The definition so far, so far as I understand it now-- Please correct me, because maybe I'm missing it. But I don't think, you see, the definition says anything about extent of involvement, degree of involvement, and so on. Does it?

DR. DENO: You could add the word "significant" before "deficits." Then you have to define what "significant" is.

DR. MYKLEBUST: You have heard Evelyn's suggestion. I don't know how far this would meet our needs.

I suppose I could ask the question this way: Is there anyone who feels that this has to be more specific in terms of extent of involvement?

Now, Jim has-- Go ahead, Sam.

DR. KIRK: If you couched it the way we do in other fields of the handicapped, such as a developmental deficit of such a nature and degree that requires special remedial techniques for its amelioration or alleviation-- In other words, this requires special remedial technique, severe enough to require that.

If it can be handled in another situation --

DR. MYKLEBUST: Now, I like these general approaches for now, and I am pretty sure that's probably the direction we have been going all afternoon. I also do call your attention to the fact that in most areas of handicapped today -- I think I'm right about this -- you do have quantitative cutoff points.

Now, Corrine, are you assuming at all for any purposes in your thinking that this learning disability involvement can be quantified?

Now, I started to say that Jim, who has been working on definitions in various ways with another committee, has indicated-- May I quote you, Jim?

DR. CHALFANT: I'm not sure what --

DR. MYKLEBUST: The three grades. May I use them as an example?

Well, I don't have to use yours. I have several of my own.

DR. CHALFANT: That was --

DR. MYKLEBUST: The point here is that for as long as I think we have had special education we have been saying he's retarded educationally if he is down a grade, two grades, three grades, et cetera. Now, Jim is suggesting something of this type for some purpose. I am asking you if that is where you want to leave it, or don't you even want to say he is down a grade? You don't want to say anything about how much he is down?

DR. BLAIR: I suppose the question is whether this basic statement has to include that or whether this doesn't go beyond the basic statement into a more, let's say, embellishment of the whole concept.

DR. SELZNICK: Looking at the application of this statement to a school system, if we did call for a certain number of grades' retardation in academic schools, it would preclude the inclusion of the child who is identified very early in the school career. It would mean the child would have to experience two or three years of school failure before he could be located in a service by which we have already determined he can benefit.

DR. HEWETT: You would have also the problem of the validity of some kind of achievement measure and what you woul use to find out -- whose impressions or what instrument.

DR. MYKLEBUST: Evelyn.

DR. DENO: It also assumes that schools are going to stay in a graded system.

DR. MYKLEBUST: I'm not happy with grades. I am saying what has been done. I don't use them. We use learnin quotients and do get at the ratio of expectancy to achievemen

I am personally committed to the ratio and to the very definitive. And in this way, as you know, under Public

Health, we are now through our second year of a massive study in this connection of learning disabilities in the public school system, and we have used the learning quotient concept, and in this way we can now say if you take a learning quotient of 80 you will have about 1 per cent of your school population that tend to fall into this category. If you take 84 or 85 or 89, obviously you have more.

We have done similar things in the deaf, the blind, and the retarded.

Now, what you are saying here, as I understand it -- and I'm not disagreeing -- is that at this time we prefer not to get into the question of how much involvement. Now, this does leave it wide open for anyone's interpretation in any way whatsoever.

I think in proper diagnosis, as Sam has stressed -- and Bill's question -- and as you are all expressing -- we probably still wouldn't include the gifted child who is underachieving. It does mean we would get evidence to the effect that he is an under-achiever and not one without these problems. That is, he does have some problems that can be manifested --

MISS TAYLOR: He has not had adequate opportunity in school. We eliminated him right there.

DR. DENO: Right.

DR. BLAIR: How might you suggest that this be included in our statement, Mike? Would you have a suggestion to make?

DR. MYKLEBUST: Not at this point I don't. I would rather see how we can say what we want to say here. This doesn't give anyone any indication of incidence I don't think. How can you? You haven't any idea how this is going to be finally categorized in any given situation, how it's going to be used, what criteria we are going to apply. So we give them the tests, you see, as we have all suggested.

Well, what cutoff point on the tests are we going to use?

Now, all of this is left out. And it might be wise to do so. But I do point out that you have no indication from this in terms of incidence.

Bob?

DR. RIDGWAY: We have another alternative, which is the one Sam suggested, and that is to insert, in place of "which can be remediable," the term "which must be" -- I think I heard you say something to that effect -- which would define these in terms of the processes used to take care of them rather than in terms of how far -- you know -- how difficult the problem is.

DR. KIRK: There is one problem about --

MISS TAYLOR: "Which requires."

DR. KIRK: -- an index, and that doesn't take us to the pre-school level. Because if we can detect these children at four and five and really remediate them, then they won't have the academic disability at an older age.

Now, we can get an index for school age kids, but how are we going to get an index for pre-school kids?

DR. MYKLEBUST: Well, Sam, it depends on how you want to do it, of course. You can get developmental indices here. In the ratio concept, of course, you can take them at any age, depending what it is you are measuring in learning. You can get a learning quotient on walking or handedness or any of these, so long as you can measure them.

But I am not suggesting we should do this. I'm sure the group doesn't want to. But I do want to point out we have done it. It's easy to do. You can get ratios on children right down to birth.

But here you can't use walking and so on very well I don't think. I don't think that would work too well.

I'm talking too much.

Jim, you're next.

DR. CHALFANT: I wanted to amend what you said. I was not referring to grade levels when I talked about discrepancies in functioning. This could be between the performance in a given process and the child's overall level of development. Or it might be a discrepancy between one process and the other, seven or eight processes, or however many there are, rather than grade level, which is very closely related to the ratio idea that you mentioned.

DR. MYKLEBUST: All right. Now, --

DR. CHALFANT: But the --

DR. MYKLEBUST: Yes?

DR. CHALFANT: Then the question is: If this is a child's level and he has a deficit of say a slight deficit here, when does that constitute a learning problem? I mean does he have to be-- How much of a difference between these educational and developmental processes does there have to be before you have a learning disability, and how much differentiation is there among normal children?

DR. MYKLEBUST: That is my question, Jim. As we have now done it, we haven't taken any position about this.

Jo?

MISS TAYLOR: Isn't it also true that in the motor handicapped and the emotionally disturbed, for instance, you have no calculator and that those working with visually and auditorially handicapped children have been fighting for years to get away from these same numerals that are medical or industrial and are transferred to education without meaning?

DR. MYKLEBUST: Well, I suppose you would have a lot of different reactions to that. I wouldn't say so, no. I think it is going quite in the opposite direction. We are getting much more statistical about it in all branches that I know.

We are quantifying pediatric findings, neurological findings, ophthalmological findings. Everybody is doing it. I think it is much more in this direction of quantifying.

And maybe we have been fighting about it. But let's face it. It's what we are going by. We are going by the 50 IQ, and we are going by the 80 db in deafness. And we are going by the 20/200.

Now, again I repeat it is not just as individuals but as society in schools. That is what I think we are doing. We do use them, don't we?

And there are also the legal problems involved. I am just trying to see problems. I don't think you can legislate about this definition we have come up with. They don't know what they are dealing with. They have no idea of knowing how many there are or what legislation would be indicated. I don't think it's possible to legislate from a definition of this kind.

DR. SELZNICK: I have in front of me the standards, the rules and regulations of the State Department of Education in Maryland. Because programs for children with learning disabilities are financed in part by the State. $800 per child per year is provided in Maryland.

"The local department of education shall provide a special program within the public school system for any child whose specific learning disorder results in such impairment or dysfunction of the intellectual processes that he cannot benefit from the instructional program usually found appropriate for most children. Specific learning disorders include, for example, problems in reception, cognition, symbolization and expression of language, problems in visual perception and integration, and a special reading disability.

"Where a group of children who have a special learning disorder can be brought together, a special class may be formed and a qualified teacher and aide employed."

And then it goes on to suggest the maximum numbers for classes.

This is very broad. They didn't find it necessary to spell out. And the State Legislature bought it.

DR. WOLFE: The first sentence includes the mentally retarded.

DR. SELZNICK: They have a separate section on that.

DR. WOLFE: I know, but let's say we are reading only that.

DR. MYKLEBUST: Yes, Bill?

DR. HELLER: Corrine mentioned this morning her first objective was the advantage of having a national definition. Now, is this advantageous, or is it advantageous to delimit and indicate the extent of the population? Because we are always asked how many at the U.S. Office of Education. How much does this include? What is the extent of this problem?

DR. MYKLEBUST: That's right.

DR. KIRK: What do you answer for the mentally retarded or emotionally disturbed?

DR. HELLER: Just about what you said the other day at the meeting. The same thing that has been answered for the last ten years. Because we have no up-to-date figures on this.

MISS TAYLOR: That is not included in it.

DR. KASS: No, it is not. But in order to get legislation in the first place, you see, you have to give legislators some notion of how many children are to be served, what the needs are. And it seems to me at one point that some sort of incidence was reported.

I think this in and of itself -- the definition in and of itself -- will give nothing in relation to national legislation unless there is some quantifiable extent, if for no other purpose than to get this started.

It is unfortunate, of course, that we don't keep our incidence figures up to date. We should. But I do know that incidence figures are being quoted at the Office of Education. As the consultant in this area I am not being consulted on this. And it seems to me that this group ought to give some thought to the numbers.

DR. BLAIR: I'm a little troubled. I sense a shift in our direction. We were talking earlier about a definition for special education, and now we are talking about what the legislators are going to read. It seems to me there are two different approaches here.

DR. MYKLEBUST: Well, I'd like to compromise here what I think we are getting, Frank. I think what we are saying is not at all discrepant with the idea for education. I do think there is one thing that is discrepant, and that is the pre-school, Sam. You and I and others would like pre-schoolers included, but that depends on how you define pre-schoolers.

If you say special education, you are talking about school age children. Then we could leave out developmental, and so on, which I believe is going to be troublesome if we want acceptance, which we do.

However, if you want it in, we leave it. But special education doesn't go down below four, five, three. I don't know. It depends on where you are. This I think is one of the things here.

Now, the other is that as special education people we are trying to get something that would be useful for legislative purposes. I think even in special education-- Let's ask Harrie. Harrie, how many do you have by your definition in your State law?

DR. SELZNICK: Well, we know specifically of approximately 200 such youngsters out of a total pupil population of 194,000.

DR. MYKLEBUST: Which would be a percentage of what?

DR. WOLFE: One per cent.

DR. SELZNICK: It is less than 1 per cent.

DR. MYKLEBUST: Now, you see, Harrie's criterion here would be a very severe one. These would be children, in terms of studies that we have done and I think other people are going by-- It would be very limited, very severe.

You can take this at cutoffs all the way up to less severe youngsters.

Now, would this be what would be useful here for some purposes? Could we do as many people are doing, as Corrine says in Washington, and certainly they are doing it in Denmark and many other places? They just simply say, "We know there are about these many." Now, you make assumptions about criteria. You don't spell them out.

For example, you can say that you think there are children up to 2 per cent or 3 per cent or 4 per cent who would fit what we have said as a group if we agree on the percentage we would want to use. We could do it this way if you want to put it in.

MISS TAYLOR: Isn't that type of information usually given in hearings rather than being part of a definition?

DR. MYKLEBUST: Yes, I think so.

MISS TAYLOR: So that really we are asking for a separate thing now. We are asking for additional information that would be helpful to somebody in hearings before either

State or Federal legislative committees.

DR. MYKLEBUST: Well, I suppose I am. I suppose that's the right way to state it, Joe. I just want to be clear that, as I see this, the application here could eliminate everybody. Harrie is eliminating everybody but 8/10ths of 1 per cent or something.

Now, that's Harrie's prerogative. He can use it any way he wants to.

Is that where we leave this now so that everyone applies it this way without any indication of extent of involvement?

DR. BLAIR: I think, Harrie, you are saying this programming you have involves 200 children, but this does not mean that you --

DR. SELZNICK: There may be many other children.

DR. BLAIR: -- don't have precise figures.

DR. SELZNICK: My budget is the controlling factor.

DR. RIDGWAY: Sam suggested 69 as a cutoff point for mentally retarded.

DR. KIRK: That's how it started. Then they went up to 75, then up to 80. Some places they were going up to 85.

We find when you get higher kids they regress to the mean of the group. So if you put the 85 with the 60, they don't get so much progress. So you begin to cut back.

If you want to be conservative, you can take a small percentage to start with to not scare the legislators, and then as studies are made you get the-- Well, for speech correction they estimate 5 per cent, 8 per cent, 3 per cent, whatever you want. What are these? Little articulatory disorders that the kid is going to get over a little later anyway. And they concentrate on those.

And the practice of speech correction in the public schools today says you have got to have a caseload of 100 or 150. So what do the poor little speech correctionists do? They get the minor cases, give them a shot in the arm one day a week or two days a week, and within a year they get over it anyway.

But the severe cases she runs away from because they take five or ten hours a week, and they don't have that much time.

Do we start with the minor ones so we can show we have a caseload of so many and get out? Or will we hit the ones that everybody is running away from?

It's a matter of judgment here. And where do you start and where do you end?

Now, you apparently got these very severe cases where the parents are saying, "Harrie, you won't put them in this class or this class. My kid is six years old, can't talk. My kid is ten years old. He hasn't learned a word."

So you take the more severe ones. If you have 200, that's the absolute minimum to me. Isn't that right?

DR. SELZNICK: You're right. But, you see, what we are not talking about in addition is the manner in which we are going to try to serve them, which relates specifically to the number you identify, the number you serve.

In many communities these youngsters are being retained in regular grades with an itinerant service being brought to them for part of the day, like speech correction service or lipreading service, et cetera.

Now, the youngsters whom we are specifically serving are youngsters with severe enough problems to remove them from the regular stream for the major portion of the day and have them with a special teacher applying special techniques and special equipment, et cetera, for practically the entire day.

DR. KIRK: Those are the 200?

DR. SELZNICK: The 200.

DR. MYKLEBUST: Yes, this, of course, is very appropriate. Now, I do want you to check me on this though. Am I wrong about this in coming back to Jo's question? Couldn't you interpret this up here as being any child in any school? Because you haven't indicated anything by way of even "significant," Evelyn. Shall we put in "significant" or what? Something specific, special?

Oh, yes, it's degree that requires special techniques for remediation, isn't it. Oh, yes.

DR. HELLER: We don't have "which require." We say "which can be."

MISS TAYLOR: "Which require" it should be.

DR. MYKLEBUST: Now, that gives us an out, doesn't it?

DR. DENO: Yes.

DR. MYKLEBUST: Sure.

DR. DENO: The word "adequate" educational opportunity defines a reasonable, regular program. It places some responsibility. And then the fact that the child requires some kind of technique which is not feasible to apply within that regular program is another defining element in here.

DR. MYKLEBUST: Yes, it is. That's good. That lets me off. That's fine, folks. That I think will hold. I think it will hold.

DR. KIRK: You mentioned, Mike, eliminating developmental.

DR. MYKLEBUST: Yes.

DR. KIRK: I wonder about that. Because kindergartens are more common, and that's pre-school. With Head Start they are starting at four.

DR. MYKLEBUST: That's right.

DR. KIRK: With the whole push we have, we are probably going to have kids four, five, and six years old. When you come to "educational," you're thinking of second-grade and above, because you don't know they are retarded. So you are eliminating three age groups.

So for that reason I believe I would retain developmental.

DR. MYKLEBUST: Fine.

DR. SELZNICK: We have been serving youngsters from two and a half on up in the areas of the deaf and in the areas of the severely physically limited.

DR. MYKLEBUST: Yes, I know. Not in this area yet is what I meant, Harrie.

DR. SELZNICK: No.

DR. MYKLEBUST: But you probably will very soon.

MISS TAYLOR: Why not?

DR. DENO: Can't you say something like "sufficiency in the development of"?

DR. MYKLEBUST: I think this is --

DR. DENO: In developmental tasks. This takes out an age factor that puts in developmental tasks typical for the age level, which is what you want. And you want a significant deficiency in the development of competencies which are related to those developmental tasks. I think that's --

DR. BLAIR: I don't like this definition on the board. I'm going to be very frank about it.

DR. MYKLEBUST: Well, Frank, we are talking about all of these combined.

DR. BLAIR: All of these combined?

DR. MYKLEBUST: We are talking about the one you have Corrine's, and this, as one.

DR. BLAIR: Fine.

DR. MYKLEBUST: I'm talking about this as one unit yet to be put together.

DR. BLAIR: Fine. Okay.

DR. MYKLEBUST: Well, are you satisfied now if we go ahead and try to put them together?

DR. ASHCROFT: Yes.

DR. MYKLEBUST: And then I am going to ask a few people to do it. I was concerned about this extent problem, and I see now that we have something which does mean he is a special child because he requires special help, Corrine.

DR. KASS: Yes.

DR. MYKLEBUST: I know you all want to work on this committee. And if you do, we will be happy to have you volunteer. I will have to start by appointing some people.

Frank and Evelyn have been working on it. Will you serve on it? Lou? Corrine, can you help with it?

DR. KASS: Yes.

DR. MYKLEBUST: Jim, you have something that you have been working on.

We have five. Would you five people then get together?

(Discussion off the record.)

DR. MYKLEBUST: Do the rest of you have any questions you want to carry on with, or do you want to take a break and come back after dinner?

DR. FLIEGLER: I'd like to ask you one question in terms of your formula which is intriguing and hopefully we're not going to miss it. If you substituted "achievement level" rather than "grade level," is this what you were really trying to get at?

DR. MYKLEBUST: Yes.

DR. FLIEGLER: If you were to push this point, is it possible in terms of your work-- And I'm going to the preschool concept here. Would it not be possible to arrive at some composite figure or statistic which is global and get that achievement level for the pre-school youngster? Is this what you were getting to?

DR. MYKLEBUST: I think it is quite possible, yes. That term isn't good there. And it probably is the weakest thing in the formula at this time. Because standardization in this connection and theoretical constrict are not very good. But we have covered I think what there is.

It is going to take some doing I think to extend this on more theoretical bases and down to the lower age levels and so on.

So far as we can see at this time as a rationale it would be quite possible to do what you are asking.

Anything else? Questions? Bill?

DR. WOLFE: I have taken the last part of the first sentence and changed it around a bit. Let me try this on you for the committee's benefit.

DR. MYKLEBUST: Go ahead.

DR. WOLFE: The first part would read, "Children with learning disabilities are those who have had adequate learning opportunities in home and in school but yet present deficits in developmental, educational, and psychological processes so severe that special remedial techniques are required."

That puts it right into our bailiwick.

DR. MYKLEBUST: That's right. I think this concept has to be dealt with.

DR. WOLFE: But "so severe" would be the point that I think would throw it into special education.

DR. MYKLEBUST: Fine. Any other suggestions for the committee?

MISS TAYLOR: I think the word "discrepancies" --

DR. WOLFE: Would be better than "deficits."

MISS TAYLOR: Yes.

DR. WOLFE: Yes.

DR. KIRK: Developmental discrepancies?

DR. WOLFE: But yet present discrepancies in developmental, educational, and psychological processes.

DR. RIDGWAY: Discrepancy can be either direction; deficit can be only one.

DR. KIRK: Why not developmental discrepancies in educational and psychological processes? Developmental discrepancies in psychological and educational processes?

DR. MYKLEBUST: I think this has been taken down here as a suggestion for the committee. We'll see what they can do with it.

Anything else for the committee?

DR. DENO: You use the term "so severe," which has a connotation for me which it probably shouldn't have, but it is just a continuum of disability, and one of the things in here --

DR. WOLFE: Depending on whether we think they are 10 per cent or 2 per cent. We are only concerning ourselves right now with the lesser of the two percentages I thought.

DR. DENO: Oh. Well, the rest of your sentence goes on about "so severe that special techniques" --

DR. WOLFE: That special remediable techniques are required.

DR. DENO: Well, it's a more qualitative thing maybe than severity on a continuum. Like a totally blind child might require almost no accommodation at all once he has learned Braille. But there is a character of something in here rather than a severity on a continuum. But maybe that's

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nit-picking.

DR. SELZNICK: No, it's important.

DR. DENO: Because the important element is that this requires something which is not feasible to incorporate in the offerings of the regular program. That is the whole concept of the child not being able to achieve adequately under the program of instruction ordinarily applied. And it ordinarily has to be a reasonable offering.

DR. RIDGWAY: The committee can decide whether "discrepancy" means either up or down.

DR. DENO: I'm nervous about the "discrepancy" and even intra-individual discrepancies. Because that immediately suggests it is nice for people to be even in everything. And I'm willing to let a kid practice for ten hours if he is a genius on the piano.

DR. RIDGWAY: I'm speaking to "deficit" rather than "discrepancy."

DR. BLAIR: Discrepancy between expected and actual achievement. I think you have covered it. I don't think there is any problem here.

DR. DENO: I think we should keep it all on manifest behavior level.

DR. WOLFE: Do we come back here tonight?

DR. MYKLEBUST: The schedule -- I hope you don't mind -- calls for us to come back tonight. And I think to get this definition problem resolved-- I think we have made a lot of progress on it. I think we have to do this tonight.

DR. WOLFE: To this room is what I am talking about.

DR. MYKLEBUST: Well, yes. How about seven-thirty? We'll set a limit of two hours on it.

DR. RIDGWAY: May I ask a couple of questions about tomorrow? I apologize for bringing up the fact we have to leave.

DR. MYKLEBUST: Go ahead.

(Discussion off the record concerning arrangements.)

(Whereupon, at 4:15 p.m., the meeting was recessed, to be reconvened at 7:30 p.m., this date.)

EVENING SESSION

7:35 p.m.

DR. MYKLEBUST: Well, you people are to be commended for your promptness tonight. I greatly appreciate your coming in like this right on time.

Now, the committee worked assiduously here, and they have a definition statement for your consideration.

As you know, they have tried to incorporate the basic aspects of all of the definitions and discussion that went on here this afternoon.

Now, the wording of the statement is here on the slate. Would you take first just a minute to read it through all the way before we begin discussing it?

Do you want to have Evelyn Deno read it for us as a group? Or shall we just take a minute for everyone to read it through? I did agree that I would try to have copies made tomorrow. Meeting at eight o'clock in the morning I won't have them for you.

If you can, it might be a little easier if you would copy it down, because I will be delayed in getting copies ready for you tomorrow morning.

(Reporter's note: The statement prepared by the Subcommittee follows:

"A learning disability refers to one or more deficits in essential learning processes requiring remediation through special educational techniques.

"Essential learning processes are those currently most commonly referred to in behavioral science as perception, integration, and expression, either verbal or nonverbal.

"Deficits are to be considered significant in terms of accepted measurement procedures in education and psychology.

"The learning disability referred to is not primarily the result of sensory, motor, intellectual, or emotional handicap, or lack of opportunity to learn.

"Children with a learning disability generally demonstrate a significant discrepancy between expected and actual achievement in one or more areas, such as: spoken, read, or written language, mathematics and spatial orientation.")

DR. WOLFE: It sure covers the waterfront, doesn't it?

DR. MYKLEBUST: So did the discussion, Bill.

DR. WOLFE: I don't doubt that a bit. Looking at the committee, I don't see how you got through.

DR. MYKLEBUST: Well, it was a real discussion. The committee really did a job in getting it together here.

DR. ASHCROFT: When you are ready, I have one comment I would like to make.

DR. MYKLEBUST: All right, we'll be ready in just a minute, Sam. I think most people are pretty well through it.

Dr. Ashcroft is ready with a comment, so will you go ahead, Sam?

DR. ASHCROFT: First of all, this is I think a very fine statement, remarkably complete and well-phrased.

I have had a continuing concern over the past several years, however, in this area. I wonder if it's worth mentioning. And I don't know what can be done about it. I don't know that I have a specific recommendation to give.

But in the last several years we have been sensitive to a lot of concerns about the traditional ways we have defined children for educational purposes. The thought essentially is this: What can we do at this point when we have an opportunity to phrase a definition and to identify a group of children to avoid some of the kinds of problems that we have fallen into with other groups of children? And I am thinking specifically of organizing the community's response to a child that they have concerns about. The concern, though we see it is widespread, is not universal.

But we're going to do something to focus, to identify, to perhaps label another type of child, and I wonder what considerations we should think about in that connection at this juncture?

DR. MYKLEBUST: Does anyone care to comment?

(No response.)

I don't want to put Corrine on the spot here. It would seem to me that probably Corrine faces as big a problem as any of us, more than most of us, in this connection. Do you have any comment at all?

DR. KASS: I think I'd have to say that in many communities in many places that I visit I find that there is an attempt to get together on the needs of a community.

At your own place, for example, George Peabody, I was in a meeting with university personnel, local school people. I don't know if there was a State person there or not.

Is this what you had in mind, Sam?

DR. ASHCROFT: Yes, partly. I think it's professional identification and also lay identification of children.

DR. DENO: You didn't mean that this definition isn't capable of being enough of a tear-jerker, did you?

DR. ASHCROFT: No, not at all. I want to avoid that kind of thing.

DR. DENO: Right.

DR. ASHCROFT: I wasn't speaking to this definition at all. I'm speaking to the general movement.

DR. DENO: Well, my own feeling about this area and why this definition seems satisfying to me personally is because I have the same concerns. The way we have defined problems in the past has not been directly translatable or relevant to education in the public mind. We have to build in a lot of bridges in order to get from that over to this.

It just seems to me that what we have done here is cast this very much in an educational frame of reference just by the term "learning disability" to begin with and saying that the nub of it is in some deficit in essential learning processes and then saying that people have a responsibility to define what they are talking about in terms that are publicly communicable, which is what that statement says to me:

"Deficits are to be considered significant in terms of accepted measurement procedures in education and psychology."

This takes it out of the bailiwick of medicine, you know, but puts it in dimensions which are translatable and relevant for education. And then the other limiting parameters in there.

And we have gone through this. We are going through it right now. For instance, I just a couple of weeks ago attended a meeting which some parents and some professionals who were a little mixed up I think had generated, where they were talking about developing a new parent organization.

We just had the Minnesota Association for the Brain-Injured convert itself to going into the ballpark with the Association for Children with Learning Disorders. And this had been accomplished, you know.

Well, now, this group comes over the horizon and wants to establish an Association for the Education of Children with Language Learning Disabilities. You know. This has gotten a big play in the papers.

And in the process of talking about this they were talking about different school systems that have no program at all for these children, and they are talking about school systems where I know that isn't true. So if you ask them and pin them down, they say what they really mean in that the school system is not using the term "dyslexia" and is not instructing children by the Orton-Gillingham Method.

I think if professionals are a little clear and have a common frame of reference in which they can talk, then we can talk better to lay people and we can communicate this to legislators. They understand it. It comes down to the terms that everybody understands -- spoken, read, and written language, mathematics, and so on and so on and so on.

It kind of works through and comes down to specific outcomes which are in everybody's language.

DR. MYKLEBUST: At the risk of sounding redundant, I think the comment is very well taken. And if we as professionals can come up with something that is workable, I think, Sam, we will avoid some of the problems which are already presenting themselves. I really think it could be a milestone.

Who else wants to comment? Bob?

DR. RIDGWAY: As I read your first sentence, I am just very pleased with this. But when I read the third one, I am not real certain what it means and how people can interpret it or how it will be interpreted.

Could some of the people on the committee speak to this?

DR. MYKLEBUST: Surely. I'm sure they would be glad to. You are talking about the one starting off, "Deficits are to be considered significant. . ."?

DR. RIDGWAY: Yes.

DR. MYKLEBUST: Corrine, go ahead.

DR. KASS: I think you're right. I sort of anticipated this. Initially, as we wrote this, the first sentence, we had in mind to define the terms in that sentence that needed defining, and these turned out to be two terms -- "deficits" and "essential learning processes."

So that initially we had the two definitions, deficits here, essential learning processes here. And somehow in the process of fixing this up grammatically and smoothing it out, we transposed these two terms.

DR. DENO: I don't know if I understand what you mean. I think what we intended was to say by that sentence that this deficit should be describable in some terms which are professionally acceptable.

You know, we should be able to operationally define this in some way that the professions themselves accept and leave the door open here for changes in measurement procedures and all kinds of --

DR. KASS: I think I can add to that explanation.

The deficits are in the essential learning processes not in the manifestation of this.

DR. RIDGWAY: I was trying to read this as some of the people on our faculty might. And I can see somebody sayin "Well, what are you talking about? If you are talking about measurement procedures, then do you mean statistically significant"?

DR. KASS: Yes.

DR. RIDGWAY: I know you don't, but --

DR. KASS: Why not?

DR. RIDGWAY: Are you talking about the 05 level or something like this?

DR. MYKLEBUST: It wasn't read into this I think I could say, but it could be if you want it to.

DR. RIDGWAY: And I didn't particularly want to. I thought it meant a significant deficit in terms of the way we measure outcomes of education.

DR. DENO: Yes.

DR. MYKLEBUST: Yes.

DR. DENO: That's what it is supposed to mean.

DR. KASS: It's not what I would mean.

DR. DENO: Oh.

DR. MYKLEBUST: All right.

DR. KASS: If I may explain the difference again --

DR. MYKLEBUST: Go ahead.

DR. KASS: -- between the deficit in the process and the outcome, that is, the achievement tests, I think these are two different things.

DR. RIDGWAY: Okay. Now let me back up, because I agree with you there, and I see the difference that you mean. But I think I see it because I am here and have participated in this discussion and others. But I am saying that somebody else who doesn't know that we are talking about process all the time when reading this definition and saying deficits are to be considered significant in terms of measurement procedures --

DR. KASS: Would it help to put this back up as the initial term?

DR. SELZNICK: No.

DR. RIDGWAY: No.

DR. KASS: All right. Then it would have to be deficits in learning process are to be considered.

DR. ASHCROFT: Would it help to put there "accepted appraisal procedures"?

DR. DENO: I think maybe.

DR. HEWETT: "Measurement" is the difficult word, because measurement cuts across so many statistical and research kinds of things.

DR. RIDGWAY: With "significant" and "measurement" together I think you are going to confuse some people. I know what we mean.

DR. WOLFE: "Diagnostic" would even be better, would it not?

DR. HEWETT: Yes, it would.

DR. MYKLEBUST: Accepted diagnostic procedures in education and psychology? How about that?

MISS TAYLOR: I think you could eliminate the word "significant."

DR. MYKLEBUST: Excuse me, Jo. Lou, you were on the committee. Do you agree?

DR. FLIEGLER: That's an excellent qualification, yes.

DR. MYKLEBUST: I think it's very well taken.

MISS TAYLOR: It seems you could eliminate the word "significant," and that would avoid getting confused with statistical.

DR. MYKLEBUST: With the term "diagnostic" in, I think we feel it is relieved. How does the committee feel about that? I think the feeling was that it wanted to stress that there should be real indications by these diagnostic procedures, and this is what the term "significant" was put in there for. Am I right on that?

DR. BLAIR: Yes.

DR. RIDGWAY: I saw two ways to do it. This is one. Another would be to say that learning disability refers to one or more significant deficits in such and such, and then say significant deficits are to be considered in terms of diagnostic procedures or something like that. This is another way to do it.

DR. MYKLEBUST: Yes.

DR. RIDGWAY: I'm not suggesting it as preferable to this one.

DR. MYKLEBUST: Well, as a group, now, what do you like? I like this "significant" up there. I'm just trying to get reaction here. What do you think? Refers to one or more significant deficits in the first sentence now?

DR. HEWETT: I think that is preferable, because "deficits are to be considered significant" sort of takes the-- Well, you're going to make a value judgment after looking at it rather than looking at it initially as a significant deficit or not.

DR. MYKLEBUST: We'll put "significant" in there in the first line if you all agree.

Then, down here where it starts "Deficits," then "significant deficits" there, Bob?

DR. RIDGWAY: Or it could be just plain "deficits" are to be considered in terms of accepted diagnostic procedures

DR. MYKLEBUST: I think it would be a little redundan there.

DR. DENO: Considered or described are you trying to say?

DR. MYKLEBUST: Now, just a minute.

DR. CHALFANT: In your first sentence, you have "significant deficits" preceding your "learning processes." I was wondering if you would want to interchange the second sentence and the third sentence to be consistent with the sequence.

DR. MYKLEBUST: Yes. Now, Evelyn, do you want to make your comment again? I think we lost it.

DR. DENO: No.

DR. KASS: You said another word for "considered"?

DR. DENO: I wondered whether he wanted "deficits are to be considered" or deficits are to be described" in terms of.

DR. HEWETT: Or "determined."

DR. DENO: Or "defined."

DR. HEWETT: Or "defined."

"Considered" makes it sound a little vague.

DR. DENO: Like we kind of sit there and admire the problem or something.

DR. MYKLEBUST: How about "defined"?

DR. DENO: That's fine.

DR. MYKLEBUST: Good. Okay. All right.

DR. DENO: Because that puts the onus then on the judge. Right?

DR. CHALFANT: One other thing. Now, the essential learning processes-- We have the deficits. Now, would you want to move "children with a learning disability generally demonstrate a significant discrepancy" closer to the rest of th body and take your negative term and put it at the end?

DR. MYKLEBUST: Say that again, Jim.

DR. CHALFANT: Well, interchange the last and the next to the last sentences.

DR. MYKLEBUST: Yes.

DR. CHALFANT: Because your deficits reflect themselves in these language areas and spatial orientation. And then as a trailer you could put on-- It seems to me that the next to the last sentence intervenes with the last one. I would switch the two. But --

DR. MYKLEBUST: All right. Some more consensus here? So we interchange the last two sentences. Is it clear and more logical? Does it flow better?

DR. BLAIR: I think it does.

DR. MYKLEBUST: Interchanging the last two sentences? Harrie?

DR. SELZNICK: I was starting from the very beginning The opening sentence refers to a learning disability.

DR. MYKLEBUST: All right.

DR. SELZNICK: Then the last sentence I like personally as a followup, because you are still referring to the learning disability and how it is demonstrated, and so it is an expansion on the initial sentence. Then moving on to the next to the last sentence. And then finally going to the other two.

It's a personal preference, thinking of the sequence and the continuity.

DR. MYKLEBUST: Let's see if we have Harry's suggestion. Corrine, did you get it? I'm not sure.

DR. KASS: Yes.

DR. SELZNICK: 1, 2, 3, 4, 5 (indicating sequence of paragraphs desired).

DR. MYKLEBUST: Do you want to try that?

DR. KASS: A learning disability refers to one or more significant deficits in essential learning processes requiring remediation through special educational techniques.

Children with a learning disability generally demonstrate a significant discrepancy between expected and actual achievement in one or more areas, such as: spoken, read, or written language, mathematics and spatial orientation.

The learning disability referred to is not primarily the result of sensory, motor, intellectual, or emotional handicap, or lack of opportunity to learn.

Deficits are to be defined in terms of accepted diagnostic procedures in education and psychology.

Essential learning processes are those currently most commonly referred to in behavioral science as perception, integration, and expression, either verbal or nonverbal.

DR. WOLFE: That reads much better.

DR. KASS: Yes.

DR. MYKLEBUST: Yes, it does.

DR. HATLEN: Okay.

DR. HEWETT: It says "requiring remediation." Does that really say it is possible to remediate? They require remediation, but you may not be able to achieve that particular goal. I'm just wondering if the point is really clear.

DR. MYKLEBUST: In other words, you are agreeing with Harrie that something --

DR. HEWETT: Yes.

DR. MYKLEBUST: But you don't object to it there, do you, Frank -- "requiring remediation"?

DR. HEWETT: No, but it may need clarification, because one of the original premises was that these deficits do be actually dealt with.

DR. MYKLEBUST: I think that's right.

DR. DENO: If you added the phrase "for its relief," that would do something at the end of the sentence.

DR. CHALFANT: Dr. Kirk was talking about amelioration earlier.

DR. MYKLEBUST: Could I back up a little bit, interpreting Harrie's comment? I'm not sure you mean this. But I thought you meant, as the committee did-- They took key words out and made a sentence descriptive of or definition or indicating the meaning of this word. I thought Harrie meant that we should have a sentence about remediation. Is that what you mean, Harrie?

DR. SELZNICK: That's as a carryover.

DR. MYKLEBUST: Not one word "amelioration" in the context but a sentence like we did with "deficits," "essential learning processes"?

DR. HEWETT: I think the term "requiring" is still going to be a hang-up. "Requiring remediation" doesn't actually imply you are going to be successful. It's the "would be nice if you could" kind of thing.

DR. MYKLEBUST: If you add a sentence, wouldn't that do it? That's what I'm hoping it would do.

DR. BLAIR: I guess we are not always successful anyway.

DR. MYKLEBUST: Frank, you recall the reason for that is that that is a way of getting it out of normal children -- because now you are dumping it right into special education. The involvement is of sufficient impact to this child that he needs special education.

Now, that's what this statement is intended to say, isn't it?

DR. HEWETT: Then follow it up with something saying it is possible to do what is expected.

DR. MYKLEBUST: I think it is very well taken. Corrine already has it.

DR. HEWITT: You might want to get rid of that second "significant." Generally demonstrate a "significant" discrepancy. It may not be necessary if you are going to change this. You have two "significants" coming very close together. The "discrepancy" I think kind of alludes to the fact it's significant after that first one.

DR. KASS: So we take out "significant" here?

DR. HEWITT: I don't think it's significant after you have that first one in, if you keep it in that order.

DR. MYKLEBUST: Yes. Would you number the sentences for us, please?

All right. Now you see the revision. Any other comments? Bill?

DR. WOLFE: Mike, what would the addition of the word "specific" before "learning disability" do to us and to the field and to the definition? It's making it something special in a way.

DR. MYKLEBUST: I want others to comment. You asked me, and I will be glad to react to it. The term "specific" here has, of course, been used in many different ways in this country and in Europe, and I know I sound grandfatherish and so on. I have heard it in so many committee meetings, cussed and discussed, and so on, that my opinion is that it would add difficulty, not clarification.

DR. WOLFE: Well, I take the suggestion from the word "significant" here. We have used it about three times. I know we have removed it a couple of times.

DR. BLAIR: Bill, one concern I would have would be that many of these problems are not specific. It seems to me that is what makes it troublesome.

I think if we were to add a word, as the State of Wisconsin has done, it would be "special learning disabilities," which I think is something you can live with because they are special.

But as to whether or not they are specific I think there is a real question.

DR. CHALFANT: The "one or more" takes care of the specific and the less specific disability also.

DR. MYKLEBUST: Yes, Harrie?

DR. SELZNICK: I'm referring back to the original invitation to this fine meeting where there is a reference to the development of guidelines for professional training in the areas of -- et cetera. And then I go to that opening sentence, and I see the word "remediation," and I wonder if in this statement there should be something about what we mean by remediation. Because it then opens the way to the guidelines that might be developed.

DR. MYKLEBUST: Yes.

DR. HATLEN: Does remediation infer that learning disability can be minimized or alleviated?

DR. KASS: Remediation means that these deficits can be alleviated given techniques based on diagnosis -- something on that order.

DR. CHALFANT: Are amenable to remediation.

DR. KASS: The idea is that the techniques must be based on the diagnosis. I mean these are not just any remedial techniques.

DR. HEWETT: Deficits can be corrected in a sense by means of special techniques based on diagnosis or-- I don't want to use "remediation" again, but --

DR. MYKLEBUST: May I suggest in Corrine's statement here, apropos of the whole discussion today and various other discussions that various of us have been in, I would like to stress educational remediation here.

DR. KASS: Okay. Educational.

DR. MYKLEBUST: In other words, not just remediation, but educational remediation.

Now, then, if you start with that, then what do you have, Corrine?

DR. KASS: Then you have remediation means that these deficits can be corrected --

DR. MYKLEBUST: Educational.

DR. KASS: -- by educational techniques based on diagnosis.

DR. MYKLEBUST: Oh, I see.

DR. KASS: Based on the diagnosis. "The" diagnosis.

DR. MYKLEBUST: Yes. Now, if you pull it back to this (indicating), based on-- It will be based on 4, won't it?

DR. KASS: Yes.

DR. MYKLEBUST: See?

DR. KASS: Yes.

DR. MYKLEBUST: Is there a better way of stating "based on the diagnosis"? Based on the evaluation procedures of education and psychology? Are we redundant here?

I can live with this idea of just --

DR. KASS: We used the words "accepted diagnostic procedures."

DR. MYKLEBUST: Yes, you have. That's right.

DR. KASS: So we are referring now to the --

DR. RIDGWAY: You could use that same phrase again and say "based on the diagnostic procedures."

DR. KASS: On the diagnostic procedures.

DR. MYKLEBUST: Yes, you could, couldn't you?

DR. KASS: Refer it back.

MISS TAYLOR: Would you read that sentence again?

DR. KASS: Remediation means that these deficits can be corrected by educational techniques based on the diagnostic procedures.

DR. BLAIR: I like Jim's idea of using the term "amenable." It seems to me that we have to be a little less than positive, because not all of these are predictably-- I think hopefully 95 per cent are.

DR. KASS: All right.

DR. MYKLEBUST: Then what do we have?

DR. KASS: May be?

DR. BLAIR: I think "may be" is a little too negative.

DR. CHALFANT: The "corrected" may be a little bit confident.

DR. KASS: Are amenable to correction?

DR. BLAIR: If you say "amenable," you are at least leaving the door open for failure in some cases.

DR. CHALFANT: Would you read that again, please?

DR. KASS: Remediation means that these deficits are amenable to correction -- "through" I guess -- through educational techniques based on the diagnostic procedures.

DR. MYKLEBUST: Now we are coming I think.

DR. HEWETT: Are we talking about sentence 6, or is that going to come in --

DR. KASS: Yes.

DR. MYKLEBUST: That will be No. 6, yes.

DR. KASS: No. 6.

DR. MYKLEBUST: Now, Phil?

DR. HATLEN: How about "remediation means the correction of"? Because I think you are giving a verb definition for a noun. "It means that these." It was "to remediate."

Then it would be --

DR. MYKLEBUST: Again, Phil, please.

DR. HATLEN: Remediation means-- Well, read yours again.

DR. KASS: Remediation means that these deficits are amenable-- Yes, means amenability to correction.

DR. MYKLEBUST: That's too awkward.

DR. CHALFANT: Yes.

DR. KASS: The term "remediation" means that-- We could do that.

MISS TAYLOR: "Indicates" might do it.

DR. CHALFANT: Treatment.

DR. MYKLEBUST: "Treatment" is very troublesome.

DR. KASS: The term "remediation" means these deficits are amenable to correction.

MISS TAYLOR: Instead of "means" could you say "indicates"?

DR. HATLEN: All right. That would be okay.

MISS TAYLOR: Then you can --

DR. HATLEN: It's not defining a specific --

DR. SELZNICK: Remediation means the application of educational techniques.

DR. HEWETT: Couldn't you solve this by putting "amenable" in that first? Learning process is amenable to remediation through special educational techniques.

DR. MYKLEBUST: If you leave out the term "requiring, you would have no criterion stated. It's the term "requiring" that puts a limit on how many you are going to get in there or who is going to get in there.

DR. RIDGWAY: Maybe the fact that the word "remediation" is underlined and sort of in quotes here solves our problem, because this makes it a noun in this sense, but it doesn't change the structure of the word.

DR. MYKLEBUST: You can say the term "remediation" refers to, and so on, if you want to I think. But let's have it now the way Corrine has it.

DR. KASS: The term "remediation" indicates that these deficits are amenable to correction through educational techniques based on the diagnostic procedures.

DR. MYKLEBUST: How does that sound to you?

DR. HEWETT: Would you say "the" or just "based on diagnostic"?

DR. KASS: I said "the" in order to refer back to --

DR. HEWETT: To be specific?

DR. KASS: Yes.

DR. WOLFE: I don't like "based on diagnostic procedures." It sort of hangs. It doesn't do much.

Read the last half of that again.

DR. KASS: Educational techniques based on the diagnostic procedures.

DR. CHALFANT: I keep wanting to move "based on diagnostic procedures" right after "remediation," but it makes it hard to define it that way. Or "remedial techniques based on diagnostic procedures." That doesn't fit the sentence.

DR. MYKLEBUST: No.

Bill, there is a little redundancy here anyway, so would you prefer "based on" --

DR. WOLFE: I'm thinking --

DR. MYKLEBUST: -- "evaluation procedures in education and psychology"?

DR. WOLFE: I would prefer "as determined" by something, rather than "based on."

DR. SELZNICK: Let me throw out another one. Remediation means the application of educational techniques based on diagnostic procedure for amelioration.

MISS TAYLOR: Oh, I think that's complicated.

DR. SELZNICK: Okay. Forget it.

DR. HEWETT: That's a three-dollar word -- "amelioration."

DR. RIDGWAY: Read the first part again.

DR. SELZNICK: Remediation means the application of educational techniques based on diagnostic procedures.

DR. BLAIR: Not bad.

DR. HEWETT: Special educational techniques do you think?

DR. BLAIR: Well, we have got that above.

DR. HEWETT: We might as well go all the way redundant.

DR. MYKLEBUST: Now, Harrie, do you have that revision, and shall we hear it again? I need to hear it again.

DR. SELZNICK: Remediation means the application of educational techniques based on diagnostic procedures.

DR. MYKLEBUST: Frank suggested "special."

DR. SELZNICK: All right. Remediation means the application of special educational techniques based on diagnostic procedure.

DR. KASS: As determined by?

DR. DENO: That doesn't say anything you haven't already said in the first sentence.

DR. WOLFE: It doesn't tell me anything new, what you have said there, that we haven't said up here.

DR. HEWETT: It's that "requiring remediation" we were trying to soften.

DR. DENO: You know, you're right. The point we were trying to make was that it required special educational techniques, so maybe it should read that way -- requiring special educational techniques for their remediation.

DR. KASS: We have already said that. It seems to me all we are defining is the word "remediation."

DR. HEWETT: Remediation means you have done the job though. If you require the special techniques to do the job, isn't it clear? If you say "requires remediation," it means you have got to be successful, whereas if you say it requires the special techniques if you're going to do the job --

DR. SELZNICK: Change the word "means" to "requires." Remediation requires the application of special educational techniques based on --

DR. RIDGWAY: You can take care of that by changing sentence No. 1 -- requiring special educational techniques for remediation.

DR. HEWETT: In other words, remediation means you have done the job.

DR.RIDGWAY: You won't need sentence 6.

DR. MYKLEBUST: Why not try that? If that will do it, it's a very great saving. Did you get it, Corrine? Requiring special educational techniques for remediation.

DR. HEWETT: Then the onus is on the techniques, not saying for sure the remediation is going to take place.

DR. KASS: Then we still must define "remediation."

(General dissent.)

DR. MYKLEBUST: I think not now, Corrine, but we will all have a second take on it. We could still use a sentence on remediation if we think it's necessary.

MISS TAYLOR: I don't think so.

DR. KASS: I think tying the techniques to the diagnostic procedures or the remediation to the diagnostic procedures is a rather smart thing to do.

DR. BLAIR: Maybe that is assumed.

DR. KASS: Do you want to assume?

DR. MYKLEBUST: I don't mean to sound pontifical at all, but it seems to me that in this sort of thing if you do add the sentence on remediation you are taking it a little out of the doubt even though you have done this at the first. The first sentence is better I think. And I think if you put this sentence on we still have the advantage of having said something about remediation.

So shall we go ahead with it and see if we can do it? Or do you think now-- Are we doing too much over again?

DR. HEWETT: I can't help but say it involves application of special educational techniques. You're just going to turn the sentence around really, aren't you?

DR. MYKLEBUST: No, --

DR. DENO: You're not defining the disability anymore when you get into that.

DR. BLAIR: I think there is something to be said for the phrase "amenable to correction" which was eliminated in the revision of that last sentence.

DR. MYKLEBUST: Yes, and there is something to be said for Corrine's point too that if you tie it to basic diagnostic procedures in a real professional sense-- Let's say we are not trying to go out and make trouble here, but it seems to me that we have reason to also assume and state that we don't just look at these children and put him in.

DR. DENO: What if you said a learning disability refers to one or more significant deficits in essential learning processes which are amenable to correction through special educational techniques?

DR. BLAIR: That's Proustian.

DR. RIDGWAY: It gets us back into the other problem.

DR. BLAIR: I think reiteration has some value.

DR. MYKLEBUST: Bob?

DR. RIDGWAY: I can see two things here. One, if we define remediation we are not really defining a learning disability. Remediation is an understood term to most of us, so that we are getting here into what you do with such a youngster.

But, on the other hand, I think I heard you saying there are people who are dealing with children with learning disabilities in ways that are not related to specific diagnoses

DR. MYKLEBUST: That's right.

DR. RIDGWAY: -- and that we at least make a statement --

DR. MYKLEBUST: That's right.

DR. RIDGWAY: -- sort of repudiating these people if we stick in something about remediation.

DR. MYKLEBUST: That's right.

DR. RIDGWAY: So even though it is not related to the definition, it might be wise to do it.

DR. MYKLEBUST: I think that's right.

Jim?

DR. CHALFANT: I keep thinking of Corrine's point here. I'm not sure if this fits. Deficits are to be defined in terms of accepted diagnostic procedures in education and psychology which lead to educational planning.

DR. DENO: What if you said deficits are to be defined and education planned in terms of accepted diagnostic procedures in education and psychology?

DR. CHALFANT: Corrine wants to link the remediation as being based on the diagnosis.

DR. HEWETT: Why not put it in the first sentence -- which are based on? Special techniques for remediation which are based on diagnostic procedures.

DR. KASS: The whole point for these additional sentences is to --

MISS TAYLOR: To clarify.

DR. KASS: -- have the first sentence the essential part of the definition, be very simply stated, and then to define whatever terms are not understandable within that statement.

In other words, what we usually get into are a lot of qualifying phrases and clauses following difficult words.

What we propose to do here is to take these words out of a simple definition and clarify it.

DR. HEWETT: Why not take "special educational techniques for remediation" out then and define that in terms of diagnostic procedures? You have taken out "deficits" and "essential learning processes." You could take special educational techniques for remediation refers to diagnostic -- are based on diagnostic assessment procedures or something.

DR. KASS: Yes.

DR. HEWETT: That would really link it, make it all solid. You have almost every word defined in the first sentence.

DR. MYKLEBUST: Here's a comment also of merit. Let's look at it. Frank suggests that we take that phrase, "special educational techniques for remediation" and then "refers to," et cetera, whatever we are going to say, as a sixth sentence.

I would like to see that worked through if we may and see how it comes out.

So, Corrine, how does yours end there? Do you want to see how it comes out, please?

DR. KASS: Starting with "special educational techniques"?

DR. MYKLEBUST: Yes, "special educational techniques for remediation means."

DR. KASS: That deficits are amenable to correction --

DR. MYKLEBUST: "The" deficits.

DR. KASS: That the deficits are amenable to correction through educational techniques as determined by the diagnostic procedures.

DR. MYKLEBUST: Frank, we run into using "educational techniques" twice in the same sentence.

DR. HEWETT: Special educational techniques for remediation are based on. What are they? They are determined by or are based on diagnostic procedures or diagnostic --

DR. KASS: All right.

DR. HEWETT: Are determined by or --

DR. MYKLEBUST: Are determined by accepted-- No, we said that.

DR. HEWETT: Arrived at or --

DR. WOLFE: Related to.

DR. HEWETT: It's awfully neat that way then. That whole first sentence comes alive without a lot of --

DR. KASS: Special educational techniques for remediation are determined by the diagnostic procedures.

DR. HEWETT: That would come after your deficits, wouldn't it? We already talked about accepted diagnostic procedures.

DR. MYKLEBUST: It will be No. 6. It will come after No. 5.

DR. RIDGWAY: No. 6 will have four underlined words, won't it?

DR. RIDGWAY: "Special educational techniques for remediation" is the term we are defining here.

DR. MYKLEBUST: Now, it seems to me we are up to this last two or three words that Bill is having trouble with, and I'm having a little trouble with them. They are based on or determined by what?

DR. KASS: The diagnostic procedures.

DR. MYKLEBUST: Determined by?

DR. HEWETT: "In education and psychology" is what you will have said before.

DR. MYKLEBUST: You will have said that. All right.

DR. HEWETT: That's right.

DR. MYKLEBUST: Bill, okay? Do you still have troubl with it?

DR. WOLFE: Yes. Let me read something here. Having it as it is right now plus the definition of the word "remediation" as No. 6, let me try this on you:

"Remediation refers to the alleviation of a problem through the use of specific techniques related to acceptable diagnostic procedures."

This is true of the word "remediation" whether it is learning disorders or cerebral palsy.

DR. BLAIR: It's a little redundant in terms of sentence No. 4, using that phrase "accepted."

DR. SELZNICK: That is the one word that bothers me most.

DR. WOLFE: I was using it intentionally here but related to the-- No --

DR. MYKLEBUST: All right, Phil.

DR. HATLEN: Is it techniques for remediation "determined by" the diagnostic procedure or the "result of" diagnostic procedure? Because you don't have anything to work from from the diagnostic procedure. From the results of the diagnosis.

DR. WOLFE: That's the thing that bothered me originally.

MISS TAYLOR: Diagnostic findings.

DR. KASS: Let me just throw this out. I don't know. So often we hear the professional diagnostician, the person talking about the diagnosis being "ongoing" and that we interpret a test and we try remedial procedures. But the remedial procedures in themselves be a diagnostic procedure and so on.

I should just like to make a case for the diagnostic procedure being just that as determining --

DR. HATLEN: Does that mean the same thing as "diagnostic procedures" in sentence 4 then?

DR. MYKLEBUST: Yes. Exactly.

DR. KASS: Yes.

DR. MYKLEBUST: Now, just a minute.

MISS TAYLOR: "Process" I would think.

DR. MYKLEBUST: You were ready, Jim?

DR. CHALFANT: Well, the thing is that the diagnostic procedures lead to the remedial techniques. Now, I think Corrine's last statement I would agree with. I'm not sure of your connection.

DR. KASS: I think the meaning is the same as saying "are determined by the diagnostic procedures," with "procedures" being used in the generic term of the whole gamut of test interpretations.

DR. WOLFE: You are not saying, are you, Corrine, that what you do with this child is dependent upon what was done in the diagnostic workup?

DR. KASS: Yes. Yes, I am.

DR. WOLFE: Or is it not determined by what is found as a result of these procedures? You see, the procedures themselves cannot or should not, as far as I'm concerned, determine how you work with this kid -- the procedures per se. What you find by using these procedures, yes.

DR. KASS: Well, except that as a clinician my procedures would be dictated to a large extent upon some initial hypothesis. In other words, --

DR. MYKLEBUST: Well, Corrine, --

DR. RIDGWAY: You are getting at the clinical teacher notion here.

DR. KASS: I guess so.

DR. MYKLEBUST: If I see the point here, "procedures" is giving us a little bind. Now is "findings" then a better term? Diagnostic findings?

DR. HEWETT: I think that's what you have got after you have done the procedures, after they have been undertaken.

DR. MYKLEBUST: Corrine, how does that sound to you? Does it sound right?

DR. KASS: It's all right. I think we are still within the problem we have of the clinical psychologist, the school psychologist, who defines the problem, diagnoses the problem, and we don't get beyond that point unless we are involved in a procedure. I'm sorry. I can't get away from that.

DR. SELZNICK: You are saying in essence that the diagnostic procedures will give direction to the process of remediation?

DR. KASS: Yes.

DR. MYKLEBUST: Yes, but we have to say it a little easier, you see, Harrie.

DR. KASS: Yes.

DR. MYKLEBUST: Now, "are determined by the diagnostic findings" Corrine feels is limiting.

DR. WOLFE: Ongoing diagnostic findings?

DR. MYKLEBUST: Well, now, we are in real trouble I think if we are going to say it is all ongoing.

MISS TAYLOR: How would it be if you said "directed by the diagnostic procedures"? That assumes that it is ongoing since it keeps directing remediation.

DR. KASS: I'm convinced that the procedure itself does dictate. The tests we use. It may be wrong, but it --

DR. MYKLEBUST: All right.

DR. RIDGWAY: Maybe the hangup here is that there are perhaps two stages of this. At one time you did some diagnostic work and used the findings in the way that Bill is suggesting. And then you determine what you are going to do. From then on you are doing some diagnostic teaching.

DR. WOLFE: I'll buy that.

DR. KASS: Okay.

DR. RIDGWAY: From that point you are doing what you are suggesting.

DR. HEWETT: One is educational; one is psychologica

DR. MYKLEBUST: Can anyone help us get this stated here?

DR. DENO: The point that we are trying to make, as I understood it, is that we are dealing with a type of disability, a deficit which we consider to be amenable to reduction if the appropriate corrective procedures are applied.

DR. WOLFE: But not diagnostic procedures. Remedial procedures.

DR. DENO: Right. So what if we say something like the term "remediable" implies that the deficit is considered amenable to reduction when appropriate special corrective procedures are applied?

DR. KASS: This isn't referring back to diagnosis.

DR. DENO: But that is what is appropriate. How do you determine what is appropriate?

DR. MYKLEBUST: That's going to give us difficulty. Every time you use qualifiers like that, you're in trouble. Immediately you ask for argument with "appropriate" and so on.

Couldn't we simplify that, Evelyn, and get this into more straightforward language like the sentences we have up here?

DR. ASHCROFT: Couldn't we just say "procedures and results"? Wouldn't that handle it? Diagnostic procedures and results?

DR. MYKLEBUST: And findings?

DR. ASHCROFT: Or "and findings."

DR. HATLEN: Now, if No. 4 is an attempt to delineat or to set up some standards, then diagnostic procedures may h a little different connotation, and maybe it is diagnostic findings there. But diagnostic procedures would fit in the other sentence about remediation.

DR. MYKLEBUST: I don't see how you can use "findings" in No. 4, because these are the procedures, the scientific procedures, evolved in the basic science manner from education and psychology.

DR. FLIEGLER: On one hand, if I might interrupt for a moment, Phil, we are talking about deficits. On the other hand, we are talking about teaching strategies in remediation. And although these are related, they are not the same thing. And I think this is what is hanging us up if I go back to your original statement, Bob.

DR. MYKLEBUST: But, Lou, we have now a revision. Could we hear it, please? Could we hear the revision, Corrine?

DR. KASS: Special educational techniques for remediation are determined by diagnostic procedures and findings.

DR. BLAIR: Corrine, I wonder if I could just build on yours. I don't know if the term "clinical" is negative, but --

DR. MYKLEBUST: For what, Frank?

DR. BLAIR: Well, if we add to Corrine's the phrase "are determined by clinical and educational diagnostic procedures," then it seems to me we are implying both initial evaluation plus ongoing possibly.

DR. MYKLEBUST: Bob?

DR. RIDGWAY: I was thinking of something like this: Special educational techniques for remediation require educational planning based on the diagnostic procedures and results.

DR. WOLFE: That's closer.

DR. KASS: Okay.

DR. SELZNICK: Yes.

DR. MYKLEBUST: Once more, Bob.

DR. RIDGWAY: Special educational techniques for remediation require educational planning based on the diagnostic procedures and results -- or "and findings." Either one.

DR. HEWETT: Would "based on" be better than "required"

DR. RIDGWAY: I said "required planning based on."

DR. HEWETT: I see.

DR. RIDGWAY: You're right. We did use "require" in the first sentence so this probably should be changed.

DR. MYKLEBUST: Now, if we are getting a breakthrough here-- Let's see. Corrine has been up writing a lot. Who would write this up for us? Lou, would you write No. 6 up for us as read so we can take it from there?

DR. FLIEGLER: I'd be delighted. This is No. 6 did we say?

DR. MYKLEBUST: Yes.

DR. FLIEGLER: Try me again, Bob.

DR. RIDGWAY: We haven't really talked about whether --

DR. MYKLEBUST: I think if we can get it up here on the board we can see the redundancies and so on.

DR. RIDGWAY: Special educational techniques for remediation require educational planning based on the diagnostic procedures -- and either "results" or "findings," whichever seems best. And your comment there is a much better one than the "require."

DR. BLAIR: If you leave out the article "the," you are less apt to be pointing to initial diagnostic procedures.

DR. MYKLEBUST: We have another change suggested here. Could we start from the beginning? Corrine, you have a change starting where?

DR. KASS: Special educational techniques for remediation refer to educational planning based on.

DR. RIDGWAY: Good.

DR. MYKLEBUST: I think the "referred to"-- Corrine makes a real point. It goes back to the sentence above. Okay?

DR. WOLFE: Yes.

DR. MYKLEBUST: All right. It refers to, meaning what we have said before. Refer to educational planning based on diagnostic procedures and results. You can't say on findings, diagnostic procedures and findings. Well, actually, that isn't grammatically correct. You have to say some kind of results there, don't you? It's grammatical, isn't it? All right?

DR. KASS: And results.

DR. MYKLEBUST: Now, you have then a complete statement up here in No. 6. How does this sound?

DR. ASHCROFT: How about putting the results before the procedures? Diagnostic results and procedures.

DR. BLAIR: They don't come in that order.

DR. WOLFE: They don't come that way.

MISS TAYLOR: Doesn't procedures also involve the results?

DR. ASHCROFT: That's right.

DR. MYKLEBUST: Well, Corrine has talked to that point here.

DR. HEWETT: "Evaluation" takes care of both, doesn't it?

DR. MYKLEBUST: Well, not in Corrine's opinion. She has been stating this here as being something involved in this process. And, of course, as I understand Corrine's point, it means that -- if I could give an example, Corrine; I hope it fits -- if someone gives a Bender, they are looking at the procedure as such in terms of implications for remediation and so on. Here you can't do it without the procedure as such. It's an active observation it seems to me. And you observe perseverative aspects and so on.

It seems to me that is what you are saying.

DR. KASS: And the choice of the Bender itself is part of the procedure.

DR. MYKLEBUST: So I suppose you can-- Well, I mean Corrine does make a point here that it isn't necessarily the same. Now, I wonder when we put "procedures and results" here whether we don't now have all that we need in it and spell it out. It's pretty clear, it seems, isn't it?

DR. DENO: Is that special educational techniques, sentence 6, supposed to discriminate between regular and special educational techniques? Is that the intent of it?

DR. KASS: Yes.

DR. DENO: But the fact that it is based on diagnostic procedures and results does not discriminate between regular and special education, does it?

DR. MYKLEBUST: No, you could do that in regular too. Oh, yes, you could. It wasn't I don't think intended to, but it is intended to tie it to objective professional diagnostic effort.

Jim?

DR. CHALFANT: I'm having a little bit of trouble here. Special educational techniques for remediation refers to educational planning. That doesn't quite fit. Perhaps I'm not thinking about this properly. Doesn't "techniques" refer to "instructional methods"?

I mean the "refers to" changes the educational planning from "requires." I could accept that, but the "refers to"-- "Techniques" does not refer to educational planning. It refers to instructional methods which are based on your diagnostic procedures.

DR. MYKLEBUST: Well, do you --

DR. WOLFE: Methods.

DR. MYKLEBUST: Let's see if we have this here. Refers to educational -- other than "planning" now. You don't want "methods," do you? I'm asking. I think that's loaded for trouble.

If we could use another term it might be easier. But what would you use in place of "planning," Jim?

DR. CHALFANT: Programming.

DR. MYKLEBUST: Programming? Refer to educational programs? Okay? Do you want to try that? No?

Frank?

DR. HEWETT: It's just that techniques don't "refer to." They are "developed from" or they are "derived from." Or you could "come up with them from."

DR. KASS: We are talking about the term, yes. This must be underlined. "The term" is understood in front of this sentence, you know.

DR. HEWETT: But it's the subject of the whole darned thing.

DR. KASS: This is the subject of the whole thing. Actually the subject is "the term." And then this apposition -- "refers to." Or "the phrase refers to." Shall we say "the phrase refers to"?

DR. MYKLEBUST: No, we didn't in the others. I think it is well understood there using underlining.

DR. RIDGWAY: It should be "refers."

DR. MYKLEBUST: Yes, you're right. That has been troubling me. Refers to.

DR. KASS: Yes, you're right.

MISS TAYLOR: I have a trouble that I just can't keep quiet about anymore. That is the very first sentence where we say a learning disability refers to one or more significant deficits. I think we either have to put "learning disability" in quotes or say "the term 'a learning disability'" or say "a learning disability involves one or more."

DR. WOLFE: That's right.

MISS TAYLOR: It has been bothering me right along.

DR. RIDGWAY: It's a child.

DR. HEWETT: A child with a learning disability has.

DR. MYKLEBUST: The committee went through that very carefully. You get into lots of difficulty in writing this if you talk about the child. Here you are talking about the problem and learning and not the child per se.

But down below you use "children." You say children with learning disability generally demonstrate, and so on.

But there are pros and cons. It started out here this evening with the child that came out this way. Do the rest of you find trouble with "a learning disability refers to"?

DR. RIDGWAY: What would happen to the meaning if the first article were taken out as she suggested?

DR. ASHCROFT: And say "learning disabilities refer"

DR. MYKLEBUST: Yes.

DR. RIDGWAY: Just one. "Learning disability refers to."

DR. MYKLEBUST: Now, that, Sam, is another problem. A great many people have questioned the use of plurals here all the time. That came up in the committee hearing. And there is reason for using this in the singular. Today the science writers and others are getting away from the plural.

Now, do you like "learning disability"? How about that, Committee? Any comments?

I think it helps it to take out "A."

Thank you, Jo. "Learning disability refers to." That does it, doesn't it, Jo?

MISS TAYLOR: That relieves my anxiety.

DR. HEWETT: At this point what about "significant"? We refer to deficits down below. Do we have to qualify what a "significant deficit" is?

In other words, we use that term, and then we only refer to "deficits" down below. What means that it is significant?

DR. MYKLEBUST: Well, how would you feel about leaving the word out entirely and not going on with explaining?

DR. HEWETT: If you put it in you almost have to. Where does "just plain old" leave off and "significant" begin?

DR. MYKLEBUST: I know. This is always difficult when you get into these qualifiers. It really is.

DR. BLAIR: It would seem to me it suggests an important problem. And we did go through this in the Committee as to whether or not we should expand on this term, getting into some kind of more precise measure. But I would feel that the term "significant" lends --

DR. MYKLEBUST: But it does leave it open to question. What do you mean by "significant"? Because you are saying the extent of it is already covered in the last sentence -- or I mean in the last part of the sentence.

DR. DENO: In the last part of the sentence really.

DR. MYKLEBUST: The "significant" in the last part of the sentence tends to be redundant. We are saying that these have the impact -- that is, that they are of sufficient consequence to require special education.

DR. DENO: That's the whole point.

DR. MYKLEBUST: Yes. And I don't think "significant" -- I'm just giving myopinion -- really adds. I think it might cause more difficulty.

And when you start getting into defining "significant" here, as Frank has indicated, it is going to be troublesome. How are you going to define it? What do you mean?

DR. HEWETT: You could just put it down in front of the "deficits" in No. 4. You could say significant deficits are to be defined in terms of accepted diagnostic procedures.

DR. MYKLEBUST: I can see that a lot more.

DR. HEWETT: That takes care of it to some degree.

Then you can let your diagnostic procedure determine what is significant or not.

But by itself up there it is kind of left hanging. If you are going to leave it, it might be better to put it down there.

DR. MYKLEBUST: Significant deficits? Okay.

DR. RIDGWAY: Did the Committee talk about the term that has been used sometimes -- "educationally significant -- " Was this discussed at all?

DR. MYKLEBUST: No, it wasn't, I don't think, Bob.

Now, let's note sentence 1 with "significant" out and see if that is the way we want it.

Sentence 1: Learning disability refers to one or more deficits in essential learning processes requiring special educational techniques for remediation.

Bob, what is the trouble?

DR. RIDGWAY: I like it better the way we did it by putting "significant" in front of No. 4.

DR. MYKLEBUST: That is what I did. I left it out. Did I read it in? Didn't I leave it out? I want to leave it out of No. 1, Bob, and I was reading sentence No. 1.

DR. RIDGWAY: I thought the suggestion was to leave it in both and make it part of the term in No. 4.

DR. MYKLEBUST: Excuse me. I'm really slow. Is that what you are talking about?

DR. HEWETT: Either that or take it out. I thought maybe it could be either. If you leave it in, it should be in both places.

DR. MYKLEBUST: Sorry, folks. I see the point now. All right. And then put it in both places?

DR. HEWETT: If you are going to do it.

DR. MYKLEBUST: That's fine. Very good. Fine.

MISS TAYLOR: I'm bothered by that "define in terms of" -- that word "define."

DR. MYKLEBUST: Now, Jo, they did sweat over that word. They went through that new Dictionary -- that big. (Laughter)

What's wrong with it?

MISS TAYLOR: I think it is really the significance of the deficits is determined by these things.

DR. KASS: May I make a point about leaving it in? Because this is our first definition. Isn't this where we begin to-- Yes, we begin to define terms from the first sentence. So that we almost have to indicate that we are defining.

MISS TAYLOR: I think maybe if we just leave out the "to be" it might work.

DR. MYKLEBUST: Yes -- "are defined."

DR. KASS: To be or not to be. (Laughter)

DR. MYKLEBUST: All right. Fine. Significant deficits are defined. I like it. That's good.

Now where are we? What else?

DR. HELLER: Just a matter of wording, but there in No. 5 --

DR. MYKLEBUST: Now, Bill, just a matter of wording? (Laughter) What have we been on the last hour? Go ahead. (Laughter)

DR. HELLER: This doesn't bear on the content because you could leave the word out. "Those currently most commonly . . ." That's awfully awkward.

DR. KASS: Yes.

DR. MYKLEBUST: All right. Leave out "currently"?

DR. HATLEN: How about "most currently" and leave out "commonly"?

DR. KASS: We could leave out "most commonly." Say "currently referred to."

DR. MYKLEBUST: How about that? Leave out "most commonly," Bill? Okay?

DR. KASS: It means this could change as new knowledge is obtained about the human being.

DR. MYKLEBUST: Yes. I think that's fine. Anyone else?

DR. HEWETT: This is silly, but essential learning processes are those currently referred to in behavioral science "as perception" or those currently referred to in behavioral science "as involving perception"? Can you have processes just referred to as perception? And integration? But does a process "involve" perception?

DR. KASS: Process is perception.

DR. HEWETT: Can a process be referred to as perception?

DR. MYKLEBUST: "As involving" is Frank's question -- as involving perception, integration. He wants to put in the word "involving" in front of "perception."

Okay? Involving perception, integration, and expression, either verbal or nonverbal.

DR. HEWETT: Will the English I-A seminar please come to order? (Laughter) We're going to diagram sentences after this is over. (Laughter)

DR. MYKLEBUST: I think it helps it.

Anything else?

(No response.)

All right. Do we all have this down? I think it will be there in the morning. But I repeat that starting at eight o'clock in the morning I will not be able to have this down for you, so you had better make copies here.

Now, if I get a copy myself I will see that copies are mailed to you after we get it typed up, and so on.

If we could go on, there is another question we should like to raise that shouldn't take very long, and this is beyond this definition. But with this definition in mind there is need on the part of many people -- I'm not talking for Corrine at the Office of Education or any other group or individual -- but there is very real need for clarification regarding incidence.

Claims are prolific today. And before we leave learning disabilities as the major problem for consideration and go on to the multiply-handicapped tomorrow morning, I would like to ask you whether it is agreeable, whether it is possible for us to agree on a statement concerning -- what is it called? -- an informed estimate as to how many children we are concerned with as people in special education and as people who must help standards and guidelines for teacher needs, for diagnostic center needs, for training grants for students, and so on.

I think if I may I won't go further into the background for the need for such a statement. Obviously I am just asking you whether you feel we can make such a statement.

If we do, obviously, it will become a part of our record of this meeting -- that it is our considered opinion that the incidence of learning disability in a regular school population is so and so.

Now, some of the estimates that you hear today are way down there, 1 per cent, 2 per cent. And, of course, as you know, they go up to 15 per cent on the part of a number of people.

In the material that I sent to you, I gave you a couple of statistical findings on incidence, and these very specifically refer only to this study and the way it was done.

Now, any statement of incidence as determined by a study refers only to that study, because it depends on the criteria we have established for it.

Now, if you use cutoff points, learning quotients, establishing average and up intelligence, et cetera, and you measure and define verbal and nonverbal problems by screening and followup test procedures, then you find that the under-achievers, the under-achievers by our criteria-- I'm giving this now only as background, not as a statement of what we should do. But the under-achievers as determined by our batter of screening tests and the criteria that we use for cutoffs-- Then 15 per cent of a school population are under-achieving, and I'm talking about school populations where there is a lot of opportunity for instruction.

Of these, something less than half, like 40 per cent of this group, turn out to have what we would refer to as learning disabilities.

Now, if you reduce this in another way and ask what percentage of the total population screened, then we come up with 4 per cent.

But now I am not down at the level that Harrie was describing this afternoon -- that severe. We are including more than that.

Now, I hope these comments are helpful. I want to get to the question and not just talk about this in this sense, because I want you to just decide and do what you feel we should do.

Do you feel that we can as a Conference Committee give an indication of the incidence of learning disability in a school population on a normative school basis? I'm not talking about then, of course, school populations that are likely to have way above average, way below average facilities, opportunities, and children, and so on, but average, normative.

Would someone care to comment? Frank?

DR. HEWETT: Where have these kids been lumped before? Have they been lumped with the emotionally disturbed kids? Are they part of that? Some guy says there's 5 to 15 per cent emotionally disturbed, about 10 per cent in general, and, you know, 5 per cent severe, and up to 15. Have these kids do you suppose gotten included in that?

DR. DENO: Some have.

DR. MYKLEBUST: Some have.

DR. HEWETT: It might not be more than 5 per cent if they were in there someplace.

DR. MYKLEBUST: Well, now, we were involved for five years in studying segments of the Chicago Public School system. This is a different system than the one I just referred to that we are working in. And we investigated this.

We went into selected schools, controlled schools socioeconomically, ethnically, and so on. We studied all of the retarded, all of the speech handicapped, all of the reading disability, all of the emotionally disturbed, all of the reading-- There were five. No, and then we had a normal control group from the same schools.

Now, you will find some of these children in all of these categories. So in a sense we are taking these children out of other groups to some extent.

Now, some of them, Frank, are also in the regular classroom.

DR. HEWETT: They would drift I could see from one category to another.

DR. MYKLEBUST: That's right. Now, we studied 200 children of each type in these schools and compared them with normal controls. And this is what we found.

Corrine, did you have something?

DR. KASS: Go ahead.

DR. MYKLEBUST: Now, Frank's question, of course, one that is very important here, is that all of these children are not new children in special education. They are just defined differently. Some of them are new. You find them, and they have never been discovered in this sense. That's true.

But, of course, I would judge from what data we have probably half of them are somewhere in some other class.

DR. KASS: May I suggest something here?

DR. MYKLEBUST: Yes.

DR. KASS: As Dr. Myklebust just indicated, incidence depends on the criteria. It depends on a given study, the way in which the study was done. Obviously we can't come to any sort of conclusion on these. But could we play a game here and take this definition? Given this definition, could each of you give an informed or educated guess? Is this fair?

DR. MYKLEBUST: Well, yes. Well, I like the question. I just want to say that, if we can, I think it would be a helpful part of this record for purposes of people that want to know what we think this definition implies.

DR. WOLFE: I don't think we should say one percentage.

DR. MYKLEBUST: No, a range.

DR. WOLFE: A range.

DR. MYKLEBUST: I was wondering if we could get a range, Bill.

DR. WOLFE: I'm going to start out, to get something on the table. 3 to 5 per cent.

DR. HEWETT: Very good.

DR. MYKLEBUST: Bill suggests a range of 3 to 5 per cent.

DR. HEWETT: I vote for that.

DR. MYKLEBUST: Frank agrees.

Harrie, you have questions?

DR. SELZNICK: I think the incidence is greater. I think that's a very conservative estimate.

DR. WOLFE: Well, we have to be in terms of what we got through saying.

DR. SELZNICK: I was looking at sentence No. 2 in particular -- spoken, read, or written language, mathematics and spatial orientation.

DR. WOLFE: With these controls built in though.

DR. HEWETT: Not sensory, emotional kind of retarded sort of factors.

MISS TAYLOR: Are you speaking about the school population or the school age population?

DR. MYKLEBUST: The total school age population.

MISS TAYLOR: Age?

DR. MYKLEBUST: Yes, the total school age. Through high school is the way I was thinking of it. Because many of these are undiscovered in high school.

MISS TAYLOR: Many of them may be sitting at home and not in the school population.

DR. MYKLEBUST: That's true too.

Bob?

DR. RIDGWAY: We screened about 1,500 kindergarteners three years ago, and we don't have the results yet, but in terms of the first part of the definition, a significant deficit in some areas, on our test battery we were getting 5 to 6 per cent. But we are not certain whether those were deficits that required remediation, and we won't be until the computer spits back at us later this month.

But I would agree with Harrie there are more of these youngsters than we have identified, because we haven't tapped the arithmetic group or the group that can't read maps.

I mean they have problems with spatial orientation, and lots of them don't come to our attention.

DR. BLAIR: I'd like to suggest 5 to 10 per cent for whatever it's worth. I think this matter of the present now, as Mike was saying, in other groups that we see, remedial reading clinics and speech clinics, and so on-- There are numbers of them there, as well as the undetected ones. I would think minimally 5 per cent.

DR. MYKLEBUST: Jim?

DR. CHALFANT: I know one of the concerns of the Office is to hold the number down to a low percentage. If you --

DR. MYKLEBUST: The U.S. Office?

DR. CHALFANT: Yes. If you have a large range-- Like in speech correction for example. The prevalence figures are somewhat comparable. You see a great range. Then in terms of those that would receive priority in treatment -- like it may be as low as 2 or 3 per cent and as high as 10 in this case. But in terms of immediate treatment, as you have done in your district, it would be directed toward the lower incidence group initially or the lower prevalence group.

Perhaps we could come up with a range and then break this down in terms of severity.

DR. MYKLEBUST: Yes.

DR. CHALFANT: In terms of treatment.

DR. MYKLEBUST: You notice there has been a suggestion of the speech handicap, the reading disability, and so on. Now, of course, all reading disabilities are not necessarily in this group. All speech handicapped children are not necessarily in this group. I think this is important that we keep in mind that we are not talking about all of them in these populations.

On the contrary, we are talking, according to the survey we have on it, only of a small percentage of these in each of these areas.

Articulation defects as such wouldn't come under the definition as I understand it. Neither would stuttering. Neither would cleft palate speech, their structural problems. They are defined out.

Emotional reading disorders are not in, you see.

Now, I would assume that is what we all mean, because that is what we have been talking about here, and I think it is very apropos that they are not all in.

Well, we have suggestions now from 3 up to 10 per cent. I think if we are going to-- I hate to give a value judgment here at this point. I'm fearful of 10 per cent myself. I think it's troublesome to many people, and I don't think we really have this kind of evidence.

Now, please don't think that we think we have any final answers, but I suppose we have studied in this study more intensively a larger population than has ever been studied. We are up to 2,000 children. In another year we will have 3,000 children. And they are very carefully defined by age and so on.

We have many basic sciences looking at them and all of this. And I really believe that some of this problem is being unduly exaggerated. It's bad enough and troublesome enough the way it is. It would seem to me that if we go over 5 per cent we must be defensive. I think so. I really do.

DR. WOLFE: I do too.

DR. SELZNICK: Well, if the statement then refers to a conservative estimate on the basis --

DR. MYKLEBUST: Conservative estimate.

DR. SELZNICK: If we say 3 to 5 per cent, as was originally stated, I don't think we will have to back down from it.

DR. MYKLEBUST: Please don't go by what I say, because it is just my opinion, like any opinion.

DR. BLAIR: We are working in the dark, obviously.

DR. MYKLEBUST: Yes. But, you see, when you go by stringent criteria, Frank, and really hold it down, you come up with about 4 per cent.

Now, you know that Denmark says 10 per cent of children have congenital hereditary dyslexia. Well, you just have to take such statements with a grain of salt. That's all. They aren't there.

Don't forget MacDonald Critchley never studied dyslexia. This is where a lot of this came from, you know, including Texas.

DR. WOLFE: He came down.

DR. MYKLEBUST: I was at his Institute in London for a while, and I can assure you he is a great man. I am not trying to detract from this man. But this is where a lot of this 10 per cent business in reading is coming from, simply quoting Hermann in Copenhagen.

And, of course, everybody has to get Critchley today. That's the only answer there is. There's nothing wrong with having this gentleman. He's a great after-dinner speaker. But I'm not going to take his word for how many dyslectics there are. He really hasn't looked at it.

DR. BLAIR: We're not talking just about dyslectics either.

DR. MYKLEBUST: No, but this is the one that gets it way out of line. It's the reading group that really throws it off.

DR. DENO: Every State now is having to submit such estimates for its State planning purposes under Title VI. It's right in the guidelines. And it is a requirement that you do so.

We had a task force on special learning disabilities in Minnesota that tried to sit down and use the data that we had that was rather firm of various kinds in Minnesota and applied criteria which are pretty well in here. That is, we were looking at functional disability which would require special educational techniques --

DR. MYKLEBUST: Yes.

DR. DENO: -- and assuming from studies that have just been done of populations placed in special classes for the retarded in Minnesota that some of those youngsters should come out of there and would be in this kind of program, which would be more appropriate for them if this program existed, and so on and so on, and that this program should serve as a placement vehicle for some children who have vision defects and hearing defects along with other kinds of things. And then there are other supports to it.

And on this basis, with this kind of figure, we are projecting on the basis of 5 per cent. And this is then with the understanding that this may cause some reduction of the number in classes for mentally retarded. There is trading of horses here.

DR. MYKLEBUST: And emotionally disturbed, and so on and so forth.

DR. DENO: Some children that have been called emotionally disturbed who would be better managed this way.

DR. SELZNICK: What do you do about spatial orientation, Evelyn? I see so many people driving cars that really ought to be screened out at some point, among other things.

DR. DENO: Well, I guess some of this boils down again to whether or not they can get along in the kind of society we have got.

DR. HELLER: At Asheville, you know, the National Association of State Directors, the figure I heard most commonly there was 5 per cent. They were talking about it within their own groups.

DR. CHALFANT: It seems like there is a consensus on a 3 to 5 per cent figure. If we stated this as conservatively estimated as 3 to 5 per cent, is this the kind of statement that you would need?

DR. DENO: You might say a conservative working premise at this point on the basis of the best information we have is that it's 3 to 5 per cent.

DR. MYKLEBUST: Are we agreed on this? Frank, can you accept it?

DR. BLAIR: Yes.

DR. MYKLEBUST: Frank Hewett?

DR. HEWETT: Yes.

DR. MYKLEBUST: Do you accept this all right, Sam

Ashcroft?

DR. ASHCROFT: I'd rather not play the game.

DR. MYKLEBUST: Now, you can't do that. (Laughter)

DR. DENO: They'll either play with you or without you, Sam. (Laughter)

DR. ASHCROFT: You know, the next question is: How many teachers?

DR. MYKLEBUST: That's right.

DR. KASS: Yes.

DR. MYKLEBUST: That's exactly the game. You are playing the game.

DR. KASS: That's the point.

DR. ASHCROFT: I have no data, so I can't make an estimate.

DR. MYKLEBUST: Well, the suggestion is that we as a group, as a committee, state something like this: The implication of this definition of learning disability is that, conservatively estimated, there are from 3 to 5 per cent of the children in the general school age population that fall within this category.

Yes, Bob?

DR. RIDGWAY: Lest someone start adding up all the categories, would it be appropriate to add to the statement the fact that no doubt some of these children are now currently being served in other programs?

DR. MYKLEBUST: Yes.

DR. WOLFE: I saw those added, by the way, one time.

DR. MYKLEBUST: Did you get over 100 per cent?

DR. WOLFE: 128 per cent, if you take the blind, the deaf, the cerebral-palsied. These health agencies, you know, use a pet figure.

DR. MYKLEBUST: That's the trouble with some of them. The statistics really get weird.

DR. WOLFE: I think this is an excellent idea.

DR. MYKLEBUST: Yes. Now, the followup statement would be along this line: That some of these children are now classified --

DR. WOLFE: In other special areas, such as -- not trying to define them all.

DR. MYKLEBUST: No. Are now classified in other special areas or in other categories of handicapped children, such as the deaf, mentally retarded, and emotionally disturbed. Is that enough?

DR. KASS: Yes. I think it's a good qualifier so people don't draw the wrong conclusions that we are going out and finding now some 5 per cent new children.

So you see, Sam, we already whittled it down to half.

DR. ASHCROFT: Very good. You might whittle it down to 5.5 per cent, and that will give it a little more authenticity if you put a decimal in it. (Laughter)

DR. FLIEGLER: May I ask you a question, Mike? In the population you studied are you including private schools, certain institutional settings?

DR. MYKLEBUST: No.

DR. FLIEGLER: Parcchial schools?

DR. MYKLEBUST: No. The selected population within the public school ~~frame.~~

DR. FLIEGLER: I hope we leave it at 3 to 5, but I would strongly urge that someone who has the facilities and the talent to explore these other areas-- Because we are talking about school age youngsters.

DR. MYKLEBUST: That's right.

DR. FLIEGLER: And my guess is that we may be close to that 10 per cent. This is just a suggestion. But this is the kind of study I hope the U.S. Office of Education does on a nation-wide basis, because this would be most instructive for all of us.

DR. MYKLEBUST: Are you making such a recommendation?

DR. FLIEGLER: I certainly am, sir.

DR. MYKLEBUST: Fine. Okay. Anything else?

DR. RIDGWAY: Off the record.

(Remarks off the record.)

DR. WOLFE: What is going to happen to this definition now?

DR. MYKLEBUST: Well, all of these discussions, as you can see, are going to be available to us. And I can't talk for Corrine and the Office of Education, but we couldn't do this without their help. And I might ask Corrine now if she has any further comment on this in terms of what she would think would be useful in terms of distribution and so on.

Do you have any comments?

DR. KASS: I should like to have this group decide after they see the transcript -- after you see the transcript, to suggest what you would like done with it. Perhaps we can excerpt some suggestions which we could then make official as the statement or statements of this group.

And we can then present these to the administration at the Office of Education and disseminate as widely as you like.

DR. WOLFE: I would hope it would get down to the so-called grass roots.

DR. KASS: Yes.

DR. WOLFE: Certainly the State departments of education at least.

DR. MYKLEBUST: Now, I like Corrine's suggestion, and, of course, now is a good time. Tomorrow we were going to try to summarize a little of this. But when we get through working here, we won't be through. We'll have to have everyone's approval of the statements here, everyone editing their statements. And I should think that it is within the realm of the decision of this group, which we will probably have to do by mail, that some publication of this could be made in a journal, a special educational journal, and so on. If we all can agree on it, we publish it as a committee that was called to do this. And this would be only if it further served the purposes that we are setting out to serve.

DR. SELZNICK: Reference was made to ACLD and the attendance.

DR. MYKLEBUST: Yes.

DR. SELZNICK: I think this is a group that ought to have access to the definition in particular so that there is communication with the action group outside the schools.

DR. MYKLEBUST: Yes. Now, I think we had thought of groups too, Harrie. Now, there are a number of groups. ACLD would be the top.

Now, I don't know the extent to which we could possibly get involved in CEC's consideration of having a Division on Learning Disabilities now. I might tell you it occurred to me a number of times today because I personally feel there are some very real problems in it.

Let's see. I can't remember if any of you are on that Advisory Council now. Jim is. You have been getting the material.

DR. CHALFANT: Yes.

DR. MYKLEBUST: I have been receiving mine. You have received some?

DR. KASS: Yes.

DR. MYKLEBUST: Well, if I may say so-- I don't know what Jim and Corrine think about this, but my opinion is that we are getting way off on a tangent where we will have a Division which is "ad limbo," not in special education, not in regular education. As a matter of fact, that is precisely what it states.

Now, so you see, it seems to me, that this effort here might be highly useful in such organizational work too. Would you agree with that, Corrine?

DR. KASS: Yes.

DR. MYKLEBUST: Any other comments?

DR. RIDGWAY: I can think of two other places that this could be useful and could be distributed with the permission of this group. One of them is that at the CEC meeting this year I am responsible for an hour on Saturday during the day when we are discussing curriculum materials centers. I am responsible for the group that will be talking about materials for learning disabilities. This could certainly be distributed there and made available to everyone who comes.

DR. MYKLEBUST: Good. What is the other one, Bob?

DR. RIDGWAY: I was going to ask Corrine's permission to use this definition in the final report I am to write up and send to the U.S. Office and it is to be published in CEC later, the CEC Journal.

DR. WOLFE: There's another organization, Mike.

DR. RIDGWAY: We can get it into print quickly if we agree on it.

DR. WOLFE: Another organization would be the Association of State Directors of Special Education. The National Society for Crippled Children. The United Cerebral Palsy. National Association for Retarded Children. These are all agencies that, if they can be sold on this thing, can really get it down.

DR. MYKLEBUST: That's right.

DR. KASS: Yes.

DR. MYKLEBUST: Well, I'm sure you feel that you have had a long day. We have an interesting day coming up tomorrow too.

Dr. Kirk asked several days ago whether he could be excused for tomorrow. We have asked Dr. Sam Ashcroft to join us. And we will make a brief preliminary statement about the tasks that we have tomorrow as we see it first in the morning, and then we will go on to this problem of definition and clarification of the area of multipy-handicapped children.

Any other comments tonight?

DR. FLIEGLER: I don't know if this is in our consideration, Mike, but somewhere along the line in something like this -- I don't know if this ought to be an organization -- we ought to include general educators.

DR. MYKLEBUST: For distribution, dissemination?

DR. FLIEGLER: For distribution, dissemination. ASCD.

DR. RIDGWAY: IRA.

DR. FLIEGLER: That's right. I think this might be a feedback as to how these people view the process. I don't know if this was included.

DR. MYKLEBUST: No, it wasn't.

I would like to say -- I think Corrine would agree -- when the times comes we will need all of these suggestions in order to make this the most useful possible, the greatest possible usefulness. I think it's exactly the kind of discussion we would like to have. And certainly there is every intention to try to get it to these people in general education. It would be very helpful.

Okay. Thanks a lot for today. See you in the morning.

(Whereupon at 9:20 p.m., the meeting was recessed, to be reconvened at 8:00 a.m., Wednesday, August 9, 1967.)

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Transcript of Proceedings

CONFERENCE

LEARNING DISABILITIES AND INTERRELATED HANDICAPS

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Sponsored Collaboratively by
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NATION-WIDE COVERAGE

CONFERENCE

LEARNING DISABILITIES AND INTERRELATED HANDICAPS

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- - -

Parkes Hall
Northwestern University
Evanston, Illinois

Wednesday, August 9, 1967

The Conference was reconvened at 8:05 a.m., Dr. Helmer R. Myklebust, Director, Institute for Language Disorders, Northwestern University, Chairman, presiding.

PRESENT:

Dr. Helmer R. Myklebust (Chairman)
Dr. Corrine E. Kass
Dr. Samuel C. Ashcroft
Dr. Francis X. Blair
Dr. James C. Chalfant
Dr. Evelyn Deno
Dr. Louis A. Fliegler
Dr. Philip H. Hatlen
Dr. Harold Heller
Dr. Frank M. Hewett
Dr. Robert H. Ridgway
Dr. Harrie M. Selznick
Miss Josephine Taylor
Dr. William G. Wolfe

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PROCEEDINGS

DR. MYKLEBUST: Good morning again to all of you.

The problem we have this morning pertains to the multiply-handicapped child. I think we all feel that this youngster has presented real difficulties in diagnosis and classification in educational remediation over the years.

I feel that if it were not for the U. S. Office's emphasis on this problem we wouldn't be as far along as we are. So to some extent I think we owe our consideration and our progress in looking at this youngster a little more completely to the fact that the U. S. Office not only does consider this youngster but provides training grants for students who are interested in becoming trained in this area of multiple involvement.

Now, this morning we do not have what we tried to do yesterday -- some position papers about the problems first. I'm going to go ahead and just make a few comments about this area primarily in terms of what we might direct our attention to today. Then Corrine and Sam will come in with their remarks too.

I was impressed with the observation of an outsider, so to speak, Dr. Smigel, when he said that to get into, to be able to function in this area of multiple involvement -- I have his quote here -- "now you'll have to know more."

I suspect that that's a rather important kind of observation -- that a person who is going to deal with these multiple involvements probably is going to have to know more.

I think this is apropos Corrine's question yesterday of curricula, of how to train, how to get people trained for these multiple problems.

I suspect we will find, despite the need to watch overcommitting these people to long-term training programs, it will be necessary to know more than if they were working in one area alone.

Now, there are various ways to approach this, as you all very well know.

I would like to, if I may, just take a brief moment to talk about what might happen in the next decade in this area of multiple involvement and thereby in the area of handicapped children.

The direction that it seems to me we will be going is towards much more information per child. The information that will be secured will I think include much of the type that we get now, but there's going to be additional information.

I think this is because of the tremendous advancements in biomedical engineering.

This I could illustrate this way: That at the present time you could take a youngster and put him in a given situation in a laboratory and automatically record his brainwaves while he's in the act of learning, learning auditorially, learning tactilly, or learning coming in auditorially and going out visually, which, incidentally, we do routinely every day in the week in one of our laboratories now.

I make the statement that if you can measure blood-pressure, temperature, pulse rate, et cetera, on an astronaut millions of miles out in space, surely you can measure some of these things in a child in a laboratory.

So to some extent -- very slightly at this time -- we hope more -- NASA is helping us, the National Space Administration is helping us, with this. Because their need is for a circumstance where what they call group environment telemetering will be necessary.

If you ask them, "What do you mean by that?" they say, "Well, you're not going to the moon alone. There's going to be a group of people."

Now this is to say that we are at the present time experimenting with telemetering from children in a classroom while they are doing anything that you ask them to do in a classroom. And this is at this time off-the-skull recording, mostly brainwaves, but, of course, you can record motor movements like this. I will get to that in a moment.

But I feel that in the next decade -- I won't stay on this question; I think we all see what we mean here -- this is the direction I believe not only in our field of special education but it is quite obvious this is the way it is going in many aspects of medicine.

And Dr. Smigel also emphasized, in pediatrics today they assume they will put a child in a given laboratory situation where he becomes a part of the total circuitry and you see what happens as all this goes through and is recorded after the child is part of this and is used as one of the ways in which this aspect of his behavior, work, whatever it is, is automatically recorded.

Well, I don't assume that we can today say that we can quantify exactly the extent of seeing, of hearing, of motor impairment, of emotional disturbance. I do suggest that the direction will be along this line and that it will be very much more so within the next decade.

We have an electronic pencil on the drawing board so that when the child is in the act of writing you can very easily put his whole motor system in the act of writing directly -- feed the impulses directly into the computer. We do that now off the tongue. And it is very easy to measure hearing this way. I think it is the way hearing will be measured. Vision is a little bit more difficult at this time.

But until we have these things more established, you and I face a lot of problems.

I don't mean this as an answer to all of our problems. You know that. But it is the direction. And I think much more quantification of certain aspects of involvement of any kind is already here, and, of course, will increase greatly it seems to me in the next ten years.

Now, we have before us, however, the question of how we might now, next year, the year after, and so on, more readily for the benefit of the child, with more accuracy, say that this child must be classified as being both deaf and blind, or deaf and motorically impaired, or emotionally disturbed and a learning disability.

You notice that on the basis of our work yesterday, learning disability is another type of handicap in addition to the others. For this morning's consideration, then, it means that we assume -- we know -- that there is a group that is deaf without other involvements, blind and hard of hearing, another category, partially sighted, emotionally disturbed, learning disability, and mentally retarded.

Now, the task before us today is the question of how to better, more effectively establish that this child has involvements of one of these in addition to one or more of the others. This is really the question here.

So a child is blind but he also has hearing loss. A child has a hearing loss but he is also emotionally disturbed. A child is emotionally disturbed but he is also retarded.

Now, I'm sure you see that in many ways-- I think of two basic things which I have already mentioned I remind you. In our culture, in our circumstances, our situation in this country right now, we are already, may I say, legally or otherwise, allocating funds for people to train in these areas. We assume they are there. And, secondly, there is the possibility that, because of the changes perhaps more in medical practice, medical science than anything else, but also I think in terms of much greater attention to culturally deprived, and so on, we are in position now to recognize that these groups without other involvement, the five areas, are somewhat less in incidence, with an increase of incidence of the "in-betweens," like the deaf with other problems, the blind with other problems, the emotionally disturbed with other problems.

This population it seems is either greater because more of these children live, survive, or are found, or whatever the reasons. The problem of this multiply-involved youngster seems to be greater than ever before.

Now, I think then that's about all I care to say at this time. We are attempting then today to see whether we might come to some agreement as to how we might refer to this let's say hearing impaired child, as an example, who has other involvements.

Taking our note from this (indicating definition on board), the way we proceeded with this definition, I call your attention to the fact that that was at least part of what I was trying to suggest in the materials I sent to you.

You notice under the deaf it simply says, and I am simply illustrating here:

"The deaf are children of school age who because of a profound degree of hearing loss are unable to learn by ordinary instructional methods."

Now, that is along the line of this (indicating definition).

Then there are variables, such as when the deafness occurred, and the degree of it, and so on.

I do not think that we could possibly today take each of these and try to come up with a definition of each of the five groups or the four. We did this one yesterday. I would hope that we could agree that some of the ways in which these groups have been defined before, particularly the retarded and perhaps the deaf and the blind -- that it wouldn't be necessary for us to go back and spend let's say a few hours on this question of the deaf -- who are they, the blind -- who are they.

No. You notice that I did make some assumption that it would be necessary for us to think about that. That is the reason I put these materials in. But, rather, how we might come up with some statement, if not definition, of who the child is now if he has both visual and auditory impairment.

Can we take a look at that a little later as one of the basic issues that we have before us today?

I don't think we need to say anything about the need. The need is very great not only from the training standpoint, from the financing standpoint, the funding standpoint, but I think from the standpoint of programs in schools. I think the need is really quite obvious.

Now, Corrine, would you go ahead, please?

DR. KASS: I would like to talk about this from the point of view of my office. I feel that my office is more or less a coordinating one. Whenever two or more handicaps are present, the program proposals must come to the office that is known as Interrelated Areas.

But it certainly is necessary to use consultants, to use experts from all of the fields concerned with the handicaps.

I think a lot of the difficulty that my panel and I went through last December in talking about the proposals was probably the term or the label of the office, and that is "Interrelated Areas."

We spent a great deal of time worrying about the interrelated concept and whether this was something different than merely an additive sort of thing of handicaps. And I don't think this was ever resolved.

It might be because "interrelated areas" is a misnomer. Perhaps it should be called merely "multiple handicaps."

"Multiple handicaps" takes in a lot of handicaps, a whole continuum of severity, all the way from the rather obvious combination of handicaps to the less severe overlapping areas that we talked about yesterday.

So a lot is included here. But whether we can talk about interrelatedness I think is very puzzling. And I wonder if you people would give this some thought and perhaps give me some suggestions about this.

Maybe we are struggling with a concept here that is just not there.

There are very few training programs being funded. There are three in the area of the deaf blind. There may be more existing. I know of only one more. There are probably four training programs in the area of the deaf blind. We are funding one in the area of the blind retarded and one I believe in deaf retarded.

Usually the practicum facilities in these programs are located at institutions. In one program the deaf blind will be housed in the school for blind. And this varies.

In one of my visits at a university I was interested in a project that was going on with the preschool deaf, with parents and children. The question was raised while I was there about what to do with a youngster, an infant, who was referred, who was deaf blind. The people in this project were quite concerned because their major focus was the deaf, and they didn't know how they could handle the deaf blind.

So I think a very important issue is: Do the personnel in these programs need a lot more education, a lot more training, or is there some other way of doing this?

DR. MYKLEBUST: Corrine has focused this very well. The terminology then becomes one of our concerns this morning, the terminology that we want to use to refer to this group.

I don't know the origin of the term "interrelated" at the Federal level. I certainly agree with Corrine that it has caused a lot of difficulty.

I think some concern here -- rather, some attention here -- from this group, from all of us, on this terminology could be very helpful, perhaps a beginning point if you don't mind.

Now, Sam, would you go ahead, please? Do you have some comments to make here?

DR. ASHCROFT: I think the major reason for my being here is so you wouldn't have to shift names today from yesterday. We can go from Sam to Sam without any trouble. (Laughter)

In reflecting on this a little bit, I have thought back to some work we did some years ago in trying to find out the incidence and prevalence of children with multiple handicaps in the area of vision, and we tried to do a survey. In trying to think of a way to define these children for survey respondents, we came up with a rather simple-minded definition, and I thought I might give you that, at least as a point of departure.

We said multiple handicapped children are those having more than one handicap each of which in and of itself would require special education services.

Then, because we knew that there would be a lot of difficulty in deciding who to report in such a survey, we asked the respondent to describe the children rather than to just enumerate them, to give us some descriptive phrases and descriptive attributes of the children.

I don't think that worked very well, but at least we did gather some data that showed at that time -- this was back in the '50's -- that at least one in five children in both local day and residential schools for visually handicapped children had one or more handicaps in addition to a visual handicap, and frequently there were two or three additional handicaps.

Of course, speech problems were very prominent, prevalent, mental retardation, and a surprising incidence of one or more additional handicaps.

We don't have good data about the incidence and prevalence of this problem. One of the best studies I could cite with respect to visually handicapped children would be the Cruikshank and Trippe study of services for blind children in New York State. About 1959 is the date. And they gathered data on more than 2,700 children and found that at least a third of them had one or more handicaps in addition to their visual problem.

Just some observations beyond the problem of defining and the incidence problem. I don't think we can put some amalgamation of two discrete training programs together and come up with a meaningful training program for children with multiple handicaps. I think we have to look at the educational provisions that are made for these children, and again I go back to that earlier survey.

We were astonished to learn that there were actually more children, multiple handicapped children, being served in local day school programs than there were in residential schools. And I think that is a serious problem.

It seems to me the residential school is uniquely suited to serve problems of multiply-handicapped children, and one of the problems we face is getting the children who can function in local day school programs out of residential schools to make room for children who have very serious problems and for which the residential school would seem to be a much more appropriate kind of place.

I think that we are concerned in our local community with multiple handicapped children, but we are anxious not to-- Well, we have talked about a special school for the handicapped in the Nashville metropolitan area, and our Department has taken the position handicapped children ought to be served in their local schools wherever they can and not assembled in a special school for the handicapped.

But a special facility such as that should be available for unintegratable children, children who cannot function in their local schools.

So this would be the kind of criterion, a kind of criterion it seems to me of seriousness of the problem that might be of some help.

Those are some random thoughts I have on the matter.

DR. MYKLEBUST: Random or not, very helpful, Sam. Very helpful. I think very interesting.

You notice that now we have before us the possibility that we should first of all consider our terminology in terms of "interrelated" or "multiple handicap."

I notice that Sam in his definition uses the term "multiply-handicapped."

Now, if we agree on the terminology, I think that Sam has given us a good takeoff point after the terminology question. Let's try to define the multiply-handicapped. He has already done it for us here. We could just take this and discuss it and see how we feel about it.

If we can then get terminology for this area that seems more effective and a definition of the whole area, then we go on and see what we can do about breaking it down. Is that agreeable?

Okay?

Now, what do you think about Corrine's question in regard to terminology? Who wants to start off here? Have you had problems with "interrelated" as some of us have?

DR. BLAIR: It doesn't mean very much certainly. It doesn't communicate I think to anybody what it means.

DR. DENO: I don't think anybody else uses it except the U. S. Office of Education.

DR. BLAIR: You don't know who started it?

DR. MYKLEBUST: No, I don't.

DR. BLAIR: It doesn't matter I guess.

MISS TAYLOR: This --

DR. MYKLEBUST: You know, I also promised myself that I would-- I hope we will all talk very freely, but it is a little hard for our Stenotypist unless I pin you down to one at a time.

What else here? Shall we go ahead on the question of "interrelated"? Do you like the term "multiply-handicapped"?

Phil?

DR. HATLEN: Well, "interrelated" seems to me to assume that you can take these children, specifically define the individual handicaps, and put them together and have something. And you don't. These kids are different from the singularly handicapped children. And it is not an interrelated area. It is a new and different area.

I can't think of a better term than "multiply-handicapped" or "multiple handicaps."

DR. BLAIR: It is "multiple" or "multiply"? Now, we see either one of these, and I think maybe there should be some consensus on this.

DR. ASHCROFT: You also see "multi."

DR. HATLEN: "Multi-" with a hyphen.

DR. BLAIR: Yes.

DR. SELZNICK: Even the term "multiple" or "multiply" or whatever means practically nothing in and of itself, because there are so many combinations. And if the term is to give some direction to the pattern of service or to the kind of training for personnel working with children with more than a single-area deficit, I wonder if we might not at least look at other possibilities.

People ask me, "Do you have classes for the multiply-handicapped"? And I say, "We have children with several handicaps, but I don't know what group you are talking about."

Individual youngsters require additional services because of particular circumstances present in the individual.

DR. ASHCROFT: Let me try an illustration for you, Harrie. I don't think "deaf blind" is adequate for even the group that have been classically defined in this way, because they are not merely deaf and blind but are developmentally retarded. Their communication problem is broad. They come with a whole packet of problems. So I don't think the discrete combination of two disabilities describes the situation.

So we can't go to "deaf behavior disorder children" and those other kinds of combinations.

DR. SELZNICK: The impact of the several handicaps on an individual will differ, and the services that an individual with the same readings would require will vary from the one to the other.

I think a term ought to give some direction. It ought to tell you with whom you are working. It ought to give you some idea as to the services that individual requires. Otherwise it is just something for convenience.

DR. MYKLEBUST: Now, I think we are well under way here. Let's go right ahead.

Frank?

DR. HEWETT: I was wondering. Historically, does the multiple handicap refer more to the physically handicapped? Has it been used more in terms of multiple physical handicaps? That's always the impact. I hear about children being multiply-handicapped, and I think of motor involvement and perhaps multi-physical sort of problems.

I wonder if in a sense we don't leave out emphasis or don't really include behavioral and learning disability.

DR. MYKLEBUST: I would certainly agree that it comes from that orientation. It did originally refer to just the physically handicapped without other problems.

DR. WOLFE: I'm having problems here this morning. I might as well get them out here at the beginning. Because I' going to have great difficulty resolving these things.

I think I am being asked to accept the idea that there is such a thing as a child with "a problem," and I don't think I can recall ever having seen a child with just "a problem," particularly after you bring in the emotional aspects, the learning disabilities now.

I am having great difficulty finding where the handle is here.

Are you asking me to accept the fact that there is such a thing as a child with a single problem -- namely, one of these eight or nine that we enumerated yesterday? If so, I am having great difficulty accepting that.

DR. MYKLEBUST: Well, here is the assumption -- I speak for myself -- that I am making. And I do try to reflect it in these statements about these groups. That is this:

It is possible educationally in schools, in classrooms, to handle some children with, for example, a hearing loss without worrying about their visual involvement, their mental retardation, or their emotional disturbance, and so on.

DR. WOLFE: No, I won't buy that last statement. I'll buy the first one.

DR. MYKLEBUST: Well, you aren't going to assume that you have to do more than what is average for a lot of these in terms of emotional? They're not emotionally disturbed. They don't need basic attention to this.

DR. WOLFE: Maybe my problem then rests with what we do or what we seek.

DR. MYKLEBUST: It seems to me you are making an assumption that everyone has to be handled as though they are emotionally disturbed.

DR. WOLFE: No, but I say that most of these, quite a few of these children are emotionally disturbed. We're going to gear our program --

DR. MYKLEBUST: That's what we're saying. A lot of them will need help for emotional problems. But I said there is a group of children in each of these areas that you classify and handle in classrooms on the basis of an individual involvement. Don't you?

DR. WOLFE: But should we?

DR. MYKLEBUST: Yes, of course. They don't need great attention to all the other things.

DR. WOLFE: But some.

DR. MYKLEBUST: Yes. I said some don't need it. Some do. The ones we are talking about here are the ones that have something, as Sam says in his definition -- one or two problems, each of which needs special education.

Well, that's all we said.

DR. HEWETT: What are the statistics? Is it about a third of what you find that would meet your definition?

DR. WOLFE: I think it's higher.

DR. DENO: It's higher.

DR. ASHCROFT: I think it's growing. It is probably well beyond that now.

DR. MYKLEBUST: Sam, could we clarify now? You were quoting a study of the blind.

DR. ASHCROFT: Right.

DR. MYKLEBUST: So this pertains to blind children with other involvements. Now, I have had a number of years of work with deaf children with other involvements. At one time I was full-time on this problem.

Now, today in schools for the deaf in this country, in classes for the deaf, the estimate is at least one-fourth. I am amazed at how close it comes to what Sam is talking about. Frankly, I think one-third of the deaf children is a fairly conservative estimate, because your rubella children also have the CNS involvement. Your Rh children have CNS involvement.

In 1946 we published our first work on meningitis deaf children. They almost invariably have other involvements like brain damage -- meningitis and encephalitis being first cousins and go together.

So today these children live. And they stay in the schools.

So this group that doesn't have the additional problem requiring special education is going down some apparently, and the group that need it seem to be going up some.

Now, does someone want to comment about retarded? I don't know what we think about that group today. How many of those have --

DR. BLAIR: We did a study in Wisconsin on the deaf which agrees with your figures. It came out to 25 per cent of the 500 schoolchildren in Wisconsin we felt had other problems.

DR. DENO: Well, in our public school program for the deaf I'll bet it's higher, because the school for the deaf is taking in the children who fit what they do, and the public school is having to accommodate to whatever is there.

DR. MYKLEBUST: That's right.

DR. DENO: And the State School for the Deaf takes in children from areas where there is no public school program available. So actually they are drawing in-- There are selective factors operating to give them a more favorable clientele I think.

It seems to me as though we get into the same problem no matter what group we talk about -- that how we address the problem is determined by our systems of service and these kinds of things and is not defined by the characteristics of the children.

So when we talk about deaf children we are always hopefully working with a mental health approach, so that whether emotional problems are present or not our management of the children reflects the fact that we are trying to maintai them in some kind of status.

I wondered in Sam's situation here where you were developing a definition for this survey-- You must have discussed and made some decision about the fact that children might have several kinds of characteristics which lend impediment to learning which if individually present might not require special educational services but in their interactive effect might add up to need for a special education service.

Your definition says that any one of them would require special education service.

DR. ASHCROFT: We didn't know how to handle that problem. But, of course, in the descriptive we got on children this frequently occurred. They wouldn't have met traditional criteria for, say, a hearing loss.

DR. DENO: Or a vision?

DR. MYKLEBUST: I think the point is very well taken. This is true, isn't it, that --

DR. DENO: Yes.

DR. MYKLEBUST: -- it's the combination?

Bill, we'll be right back to your question. Bill has raised a very basic question on assumptions which must be resolved for our discussions today. We will be back to it in just a minute.

Go ahead, Jo.

MISS TAYLOR: I have nothing more to say. It was already said.

DR. MYKLEBUST: All right. Then Jim.

DR. CHALFANT: I think this relates to your comment. Some concern has come up over what to call the children, and it is a question of "handicapped" being tied in with etiology. We might follow the lead something like this -- of those children which require more than one special educational service.

DR. MYKLEBUST: All right. Let's keep this in mind. I'm going to ask us to again look at the question Bill has raised, because it is a basic assumption in the discussion.

Go ahead, Bill.

DR. WOLFE: I would like to raise another one or point out another feeling I have, Mike.

DR. MYKLEBUST: All right.

DR. WOLFE: If we do relate to this child as though he had a single problem, is it not true that the longer we relate to him in this way the greater the chance of him becoming multiply-involved?

MISS TAYLOR: Yes.

DR. WOLFE: Yes, I think so.

Now, if you say yes to this, you are going to get yourself on my side on the first one, so I would suggest that you weigh your answer. Because if we treat a child as having problem A, and it is a single entity here, nothing else is being done, the longer we allow him to live in this what I would call somewhat sterile environment as far as his other needs are concerned, he's going to feel the need for other things.

I'm bringing in again the emotional bit.

DR. MYKLEBUST: Bill, --

DR. WOLFE: If we work with him say for four or five years, it may be that he will now need the special education services provided to the emotionally disturbed because of lack of attention in the first few years.

DR. MYKLEBUST: Well, I'm not sure I follow, but it seems to me the assumptions you are making here I wouldn't say yes to at all.

In other words, I agree with Evelyn that you use the mental health approach to all children and the same as any other group of children.

MISS TAYLOR: That's part of the treatment of that one.

DR. WOLFE: Should be. Let's be realistic.

DR. MYKLEBUST: You're not isolating him so that you are making problems. I don't see the assumption at all.

Go ahead, Sam.

DR. ASHCROFT: I'm not sure I understand what you mean, unless it is this: That the cliché in special education has been that when you have a child with multiple problems that you treat him in terms of the basic problem.

Is that what you are talking about? Is that what you mean by the single problem?

DR. DENO: Or the impairment.

DR. MYKLEBUST: He's talking about the five groups here.

DR. WOLFE: I'm talking about the single problem that I'm asked to accept. And I have difficulty accepting it. But I will go along with what you are saying then. The same thing is true here in what you are saying.

DR. MYKLEBUST: As I understand, now, to get this straight here, Bill's feeling is that there is no such thing as a hearing impaired or a visually impaired or a motorically impaired child that should not be considered multiply-handicapped.

DR. WOLFE: No, no, no. I wouldn't go that far.

DR. MYKLEBUST: That's the assumption you're making.

DR. WOLFE: No, no. I said --

DR. MYKLEBUST: Where do you cut off? Then there is no disagreement.

DR. WOLFE: We don't have adequate statistics on this is what I am saying. I think finding a child with "a problem" would be rare. I'm not saying all. I wouldn't indeed ever say that.

DR. MYKLEBUST: Well, we are not concerned about the actual statistics here this morning. Our concern is that there is a group of children with a given handicap that are classified and managed educationally according to the given handicap.

DR. WOLFE: Right.

DR. MYKLEBUST: All right. Then the other assumption is that there are those who have more than a given handicap and must be handled and educated differently. They have different personnel training problems for them, and so forth.

DR. HEWETT: Sam, were you referring to children who had a defined primary handicap and some additional secondary handicaps that happened to be troublesome enough so they would also require special education? Or were you talking about a kid with three or four primary kinds of handicaps? Are these additional handicaps always secondary? Or can they all be of equal --

DR. ASHCROFT: I think we have talked as if they were secondary. We have frequently said, you know, if we had a blind retarded child, that he is a blind retarded child, not a retarded blind child, and, "Therefore, he's the responsibility of people in mental retardation. We in the blind, you know, can't dirty our hands with him because his more basic problem is the retardation. If you can remedy that, then we will take him back as a blind child and we can do something for him."

DR. SELZNICK: Look at the other side.

DR. ASHCROFT: Then the retarded people say, "He's not a blind retarded child. He's a retarded blind child, and he's your responsibility. If you can handle the blindness, we will take care of the retardation."

DR. HEWETT: So we have different kinds of problems here. We may have across-the-board primary, and we may have some secondaries and a couple of primaries, and we --

DR. ASHCROFT: That's why I don't think, you know, trying to find "the" basic which is primary and which is secondary-- I don't think that helps us at all.

DR. MYKLEBUST: Well, it may not. And, if possible, then, we would not try to say what hierarchy of pecking order we are going to insist on. It seems to me this must be left to the school systems, to the programs in the States. But, rather, that there are these children that need attention irrespective of what the hierarchy of involvement might mean.

DR. WOLFE: When you say leave it to the schools, Mike, watch out. Because in our State we have the ridiculous interpretation in our State guide which says that if a child has multiple involvement, mental retardation being one of these, then mental retardation will take precedence over all of the others and he must be included in the mental retardation program.

This is totally inadequate, ridiculous.

DR. MYKLEBUST: Well, I can certainly see it would cause problems, Bill.

Does anyone else have that?

Yes, Jim?

DR. CHALFANT: Well, I'm sorry. I --

DR. MYKLEBUST: I was just going to say now that States will vary a great deal. I'm just expressing my opinion. I certainly agree with Sam's comment that this is very difficult on a hierarchical basis. Though in this I do discuss somewhat the major handicap concept in the material I sent you. I admit it. This is one of the ways it has been approached for many years. I don't feel that it is critical, however, to the concept of multiple involvement. Multiple involvement will be variously interpreted then in different settings, and so on, as to which is major and which is the basis for the major classification. I think they are fairly separate issues.

Jim?

DR. CHALFANT: Now, with respect to this multiple involvement, which is another way to get around this handicap problem, it seems there are two or three blocks here.

First, you get into combinations and permutations when you deal with the etiological aspects, the kind of disorder.

And then the question was raised over here that some of these things should not be etiologically described but they are of sort of a functional nature.

And, third, the question was raised of the problem of providing services.

Now, one way to handle this might be to focus on the service necessary for these involvements rather than on the etiological disorder.

DR. MYKLEBUST: Now, you're not going to refer them as visually impaired or retarded or anything, Jim. Is that etiology here in this sense? I'm not sure what you mean.

DR. CHALFANT: I was thinking in terms of a definition, if that's what we are still after.

DR. MYKLEBUST: Yes, Evelyn?

DR. DENO: I think what Jim is saying relates to the same point that I am always uncomfortable about. I think we use these terms which have just come to be handles on communication over the years, of hearing and vision and so on, as though, you know, we are using them because the etiology is the significant thing here, which I think maybe it is.

But when you are talking about the deaf and you are talking about vision, and so on, you are really talking about the modal cluster of services which has developed around some needs of these children.

So when we say "deaf," we really mean children having a modal cluster of needs. This is what we mean, but we kind of short-hand and say "deaf children."

So this kind of fits in with what you are saying and may be why there are only three or four programs, because it's the children who can't be served through these systems that have ordinarily been developed around these modal needs. And then we get into some special kinds of systems here which require a complex of services which is very broad and interdisciplinary.

DR. MYKLEBUST: All right, Jo.

MISS TAYLOR: I think another situation here, which is what I thought Mr. Wolfe was saying-- I think those of us who work chiefly with one type of handicap, of which there are only a few here, or one, whatever you want to call it, are aware that there are many other children, let's say visually handicapped, who have additional problems which may be rather minor compared to the blindness but which if not given attention will develop to a point where they really will need more serious services.

So that programs and teacher training programs have become aware of the fact that many of the teachers trained let us say to work with visually handicapped children don't know enough about other ways of treating other serious problems such as learning disabilities and therefore are asking for special training for this.

My question is whether this should be in a special training program for a particular cluster of handicaps or whether there is some better way of providing this.

DR. MYKLEBUST: Very helpful. You see, the question is then whether you really need the multiply-handicapped as something unique and different. And this is very apropos to this discussion.

I think some of us feel that you do, that you do need some way of approaching this.

I am still unclear about the etiology thing. If you mean you are going to handle deaf children, blind children, retarded children as a given entity, I think that is going to be extremely difficult. I think there must be consideration for the types of involvements we are talking about. After all, this is the way behavioral science works. It is the only way you have knowledge about anything.

It would seem to me you would have to have knowledge about hearing loss and its effect on the psychology of learning, visual impairment and its effect on the psychology of learning, brain damage, dysfunction of the brain, and its effect on the psychology of learning. I think this is where we could get together and have the psychologies of learning as we begin to see them in relation to given aspects of handicap, given involvements of the organism.

Now, Harrie, you have something?

DR. SELZNICK: I just wanted to get this out on the table. You know, a few years ago -- actually, over a number of years -- the Council for Exceptional Children had its special study on the preparation of professional personnel to work with exceptional children. That wasn't the exact title. And various task forces each investigated the various categories to which we had assigned youngsters.

Each came up with what it suggested as an appropriate training sequence, various experiences and understandings to be promoted, but at no point along the way was there cross-fertilization and an effort to identify the areas of commonality -- that is, what was basic to teaching children whether the deficit be in one area or another.

And maybe this has a relationship to what we are talking about now. And instead of trying to set up a new sequence, a different sequence, we ought to try to identify more specifically what is common to the needs of children in whom we find more than a single deficit and for whom services have to be organized.

DR. BLAIR: I think it is a good point, Harrie. I think all of this does relate to how we train teachers ultimately, and I think the primary disability concept has some validity in these terms.

At the same time, I think there is a need, as we are trying to do in our department, to bring various exceptionalities together in terms of training. We are trying to set up core courses. We have developed one in language development for exceptional children, which we think will serve many areas, you see, because language is certainly a common area of need here for all children.

I think as we think of the ultimate goal here -- that is the funding of training programs -- I think this primary disability thing may still have some real validity in those terms.

DR. MYKLEBUST: Okay. Are you ready to consider more specifically the question of whether we want to change terminology? We have been talking about concepts. Are we ready to look at what this concept we are talking about might be called or how we are going to identify it?

Bob?

DR. RIDGWAY: I twas just thinking that it seems to me that when we said we had programs for the blind, the deaf, or retarded, and so on, we were talking about programs for particular kinds of children. I believe the term "interrelated" has its greatest meaning when we think of it not as the children being interrelated but a program relating separate programs together, like deaf programs related to blind programs.

I mean this is the only way the thing makes sense to me, that this was the handle that the Federal Government put on this to have one category to talk about or one label for deaf blind, blind retarded, et cetera, to lump them all together like the other health impaired can mean so many different things.

But it was a term that was useful as a catch-all. And it seems to me that as I have listened here I have heard people saying, "Don't try to get a single term like 'multiply-handicapped' because this really doesn't mean anything." And people have suggested that if you mean programs for deaf blind, then say programs for deaf blind, or use terminology that helps you determine what group you are talking about.

We know we have so few such programs that maybe for Corrine's purpose we have to have a basket to put them in.

DR. MYKLEBUST: It would seem to me that is very important also for the field -- that we have something to designate this very obviously overlapping kind of problem.

Yes, Bill?

DR. WOLFE: I believe, Mike, we should look at the term "interrelated" referring to the training program at the college and university level and not out in a public school setting.

We are working out there with the multiply involved, but we are training our teachers through an interrelated program.

Do you see what I'm trying to say here?

DR. SELZNICK: Yes.

DR. MYKLEBUST: Yes.

DR. WOLFE: Because, you see, in the setup in the Office you are describing with this term, the kind of a training program which you would fund, those people who would come from that kind of program then would go out to Baltimore and work with the multiply involved.

DR. SELZNICK: Good. Thank you. (Laughter)

DR. WOLFE: This is the way I see "interrelated."

DR. MYKLEBUST: We see your point. I'm having difficulty though with we as a committee trying to come up with terms for programs in universities.

First of all, it wasn't an assumption at all that we would get into this. If we must, we must. But I don't think it's going to work. I think this is quite a different kind of task force or question.

I think that our problem is children. There are many implications for training. I think all of the implications for training are excellent, any of them that we can come up with. It wasn't assumed that we were going to try to set up a university training program to designate them by terms or anything else. But it was assumed that we would like to have better terminology, clarification of the groups of children who need services from universities as well as anybody else, everybody else.

In that sense, to try to designate "these are programs for universities" I think is very difficult.

I think there is an area here that we're overlooking in a sense. That is, these children aren't being designated today in a helpful manner. And, say what we will, what you call them makes a difference. What you call these (indicating definition on blackboard) makes a difference.

Symbolic behavior in man being what it is, it's going to make a lot of difference to children.

If we call them "interrelated," there is one thing. I don't think it will move very far. I think the term has worn itself out.

I think "multiply-handicapped"-- I'm only trying to get us to move on if we are ready to. "Multiply-handicapped" does communicate to some people. I think it communicates very effectively to a lot of people.

Now, maybe we can come up with better terms. I don't think we can agree on the terms that you are going to call the deaf blind and all of the in-between groups. It seems to me now we have to have the profession of the blind, the profession of the deaf and others involved. We do cross over these things, but we're not going to be able to tell these groups at this time I don't think what they can do about this in the subcategory kind of classification nor the hierarchy.

I would like to see something that would be useful just as we have done here in a general way to designate a group of children that today it seems to me in a way are seriously in need of further designation, and that's the overlapping groups here. I think this is a question Corrine is raising.

Bill?

DR. HELLER: Well, to me -- and, Corrine, correct me if I am wrong -- "interrelated" as I see it in the Office was a means of bringing in not only multiple handicaps but also bringing together, for example, disadvantaged and MR. We ship those to you as interrelated proposals.

Also it was a vehicle for bringing together programs in regular elementary and secondary education in conjunction with special education programs.

In other words, thinking of the philosophy that was going on back in the Office at the time, this was a kind of an intermarriage type of deal.

So "interrelated" here doesn't refer strictly to multiply-handicapped things. It's a means to interrelate different types of educational programs, whether they be special education or regular education.

DR. WOLFE: This is the point I was trying to make, Mike.

DR. MYKLEBUST: Then you have a certain need for something there that is not what we are mainly concerned with.

DR. HELLER: Right. It doesn't communicate at all -- that term -- to what we want it to.

DR. MYKLEBUST: No. Any other comments here about the terms?

Lou, go ahead.

DR. FLIEGLER: I'd like to ask Sam a question. He made a very telling point which makes a great deal of sense when we are talking about retarded disturbed kids or disturbed retarded kids.

You say these programs, talking about the blind and the deaf, you do not see as discrete programs, but as a new kind of combination. I wonder if you could explore that. Because, as Bill says, it is true we have been training our teachers of mental retardation and giving them a course in emotional disturbance, because most of the kids you find in a special class are emotionally disturbed.

To some degree we have been doing this in the area of the deaf.

And Sam has a new tack here that I think may not help our terminology but it certainly will guide us in the kind of directions we may want to go.

DR. ASHCROFT: I'd like to respond to that.

First, this may not be directly germane, but it is interesting to me to reflect on why these children became designated as deaf blind children rather than blind deaf children and why the programs for the blind happen to have these children when, gee whiz, you know, the language development problem for these kids is the really tough one.

And I like what Frank has suggested is going on in his program -- some core courses that cut across these areas. And language is certainly one of them.

And so we feel in our program preparation that language development, language disorders and what we can do about them, is a central part of the program preparation.

I would be willing to dispense with a lot of the stuff we give routinely to teachers of visually handicapped children in favor of emphasis on language disorders.

I would like to dispense with some of it in favor of some help with behavior modification techniques, because I'd like to see our kids have much more of that, and to heck with the Braille. Anybody can help these kids acquire a reading skill through Braille -- if we can get their behavior shaped up a little bit so that they can relate to people and can, you know, be a member of a group and that kind of thing.

Well, in our own program we have resorted to trying to pull from all of these areas. We had an educational procedures course in each area, and we tried to pull components out of those for an educational procedures in special education, so we get rid of all the kids, deaf, blind, disturbed, retarded. And they are getting the same song and dance in each.

DR. MYKLEBUST: May I respond to that just for a moment? I think it is a very vital issue.

DR. FLIEGLER: Yes.

DR. MYKLEBUST: I agree entirely with what Sam says and would be delighted with certain core approaches to training of people in specialized areas.

I would like to see some course work -- and we are going in this direction -- which considers the impact of a given involvement such as deafness and blindness on learning. So we are talking about the psychology of learning.

Of course, we have a course in the psychology of learning on the deaf, such as psychology of deafness, which is the way it impairs or affects learning. Now, if we then would say that if there is an impact on learning from a given involvement such as deafness, and if we say there is a shift in learning processes in the blind, it seems to me that the new area is how these interrelate.

The psychology of learning of the blind isn't necessarily directly related to the psychology of learning when you are both involved with hearing and visual impairments. But there is again a new psychology of learning.

This is essentially what we would feel would be new in kind of a combination of things.

To take it one step further, the kind of thing Frank is so heavily involved in-- I guess I said a little of this yesterday, didn't I? There may not be the same parallel to the psychology of learning in the emotionally disturbed. That I don't know. I just say that it is a little different kind of situation. Perhaps you are assuming something a little different here.

But I made the statement for one of these that a

70 or 80 IQ deaf boy, you see-- Let me put it like this: An 80 IQ deaf boy needs special education with a vengeance, whereas an 80 IQ hearing boy might go in the slow learning classes in the regular school system. But not when he is also deaf.

So it isn't just additive. Now you have a combination which makes him a different individual and an individual for whom special education is extremely important because he does have potential for making out in life if it can be achieved.

So Evelyn Deno's comment I am very impressed with -- the fact that so many mildly hard of hearing children get to special education but they have multiple involvement, don't they, Evelyn?

DR. DENO: Sure.

DR. MYKLEBUST: They have other problems than the hearing loss. Now, if it were only the hearing loss, they wouldn't be with you, but they are in the programs for the hard of hearing. They are there because they are identified with the hearing loss or with the audiometer, and so on. But they have a learning disability or they have emotional problems so they are in the program for the hard of hearing.

DR. SELZNICK: May I make a comment about operations?

DR. MYKLEBUST: Sure.

DR. SELZNICK: You know, each of us speaks fromhis own orientation and experience of course.

DR. MYKLEBUST: Yes.

DR. SELZNICK: I have classes for deaf retarded children, or retarded deaf children -- I don't know what you call them -- but it is basically a determination made on function, observation and study.

Now, I have looked for personnel for these classes. We have four such classes. And I have had teachers whose primary training was in the area of the deaf who have taken additional work in mental retardation. I have had teachers who have come from the area and have been trained to be teachers of the mentally retarded who have worked and who have been given resource help and taken some training in education for the deaf.

I don't know which is the better prepared person. I think it's individual.

We have classes for orthopedically handicapped retarded children. We have eight such classes. And it isn't so much the orientation and the preparation as it is the individual. Someone, someplace along the line, has given the teacher sufficient understanding of children and growth experience so that they have been able to perform satisfactorily with children.

Now, I think school systems are going to continue to staff-- Hopefully, the training centers are going to provide the broad background which will permit people to serve children -- period -- rather than to serve diagnostic labels.

DR. MYKLEBUST: But you do assume that these people achieve proper certification in given areas?

DR. SELZNICK: Yes, but that doesn't always insure a thing. That doesn't insure much.

DR. MYKLEBUST: I didn't say it insured anything. It makes it legal.

DR. SELZNICK: Or legitimate.

DR. MYKLEBUST: I'm saying we in training centers can't avoid the fact that we must give them certification in something.

DR. SELZNICK: Yes.

DR. MYKLEBUST: Otherwise you people can't hire them legally, and you can't get reimbursement and so on.

So, of course, we have got to have enough of a program ina given area so that we do this. At the present time it seems to be just being practical about it, or you can't get people into jobs.

Yes, Phil?

DR. HATLEN: Just to reiterate in a way what you were saying, in the past year I have seen a lot of deaf blind children and a lot of deaf blind preschoolers. I call them deaf blind. They're really not. They are very multiply-involved in addition to deafness and usually some visual loss but certainly not blind.

These kids don't fit into any cubbyhole. This is a different type child. I have taught blind children a long time, and they are not blind kids.

And Miss Jackson, whom I have been working with on this, is convinced they are not deaf children either.

We have, as I stated the other evening, some real problems in a curriculum in this area for this coming year. We think we are going to offer sort of a cross-section of courses which we feel will be beneficial. But the courses which we believe are going to be most helpful for the people whom we will be training as teachers of deaf blind are the ones that will be specifically in this area, and they'll be very much internship type programs where they get out with children.

One of the things we want very much to do but we don't feel we are going to have the time -- and this relates a little bit to what you were saying -- is that we want these people to get out and observe normal child growth and development. We would like to put them in hospitals and observe what normal infants do in development from very, very early infancy. Because some of the rubella children that we have seen are very grossly retarded developmentally.

It depends on time. We don't know what we are going to be able to do in this respect. But is certainly a different type child.

As far as certification is concerned, we went up to Sacramento and talked at length with people in the credentialling office about a credential to teach deaf blind children in California.

A bill was just recently passed in California making it possible to have a restricted service credential, which means-- Well, we have complicated credentialling procedures anyway, but it means, in effect, that a person can receive a credential, for example, to teach the deaf blind and not teach in any other program in California.

We are not sure we want this, because we think we are opening the door to any number of little tiny credentialling programs of dual handicapping conditions.

And it seems to me that there is a core. There is something basic to working with kids who are multiply-handicapped that we don't have to become so definitive about the individual types of handicaps. And yet they are different kinds of children.

I don't know what the answer is. I don't know a better term than "multiply-handicapped."

DR. MYKLEBUST: Frank?

DR. HEWETT: I think this all leads us to maybe reconsidering the point that Harrie made. What I think really is needed in the field is not as much only focus on the five or six or seven little circles that Sam drew with slight overlap but a great big circle into which all of these might be placed and where the common kinds of deficits that keep these youngsters from learning are spelled out, so that we deal with them in frameworks that have applicability to the entire group of handicapped children.

I think this is an important kind of thing to consider. And something we have been trying to do is to think of emotionally disturbed children as learning problems, retarded children as learning problems, and attempt to define what is it that they need to learn that we can do something about.

I think this will help us in dealing with multiply-handicapped children, that we have a common denominator that we can work toward with the whole group.

The sickest children I have seen are deaf-disturbed children, or the reverse. The psychotic deaf child is the most disturbed child we ever see in the hospital or I have ever run across. They are different. And yet they are related. And I think we have to have common kinds of things that we can work with.

DR. MYKLEBUST: Well, I think one way to view this discussion is that some of us look at this as generalists and some of us look at it in other than generalist terms, more in terms of a specific science and given involvements together with other involvements, and so on.

We have been through this a lot in this State too in recent years. A center that trains almost-- Well, it trains a generalist to go out and do anything with handicapped children. I think this goes much too far. I don't think this person really-- As an individual, anyone might make it, Harrie, but in terms of proper background of basic science and psychology of learning in relation to given disabilities I think each of these has a tremendous significance -- tremendous.

Just the effect of lack of sensory impact on the brain-- We are beginning to collect the brains of both deaf and blind. We have already a neuropathologist working on it. And it is very obvious that lack of stimulation in some areas of the brain causes changes in the brain. It has been known in lower animals for years. The old physician in London who did the post-mortem on Laura Bridgman said so on Laura Bridgman. I quoted his report. I looked it up and brought it into my discussion of Laura Bridgman in my book, "The Psychology of Deafness."

There are fabulous neuropathological implications, not just emotional, psychiatric, important and urgent as they think they are. But there are many problems here. And I think it depends on what we want.

Again I say we will have to go the direction the Committee wants to go, but I didn't think we were going to spend our day talking about how to train people to do this -- at least not until we have a little bit more idea of what we are going to call the group or whether we agree that this group is there, which is Bill's question.

And again I say if we agree they aren't there, if we are going to treat them all as one big category, really today is more or less out. We don't need today.

I'm trying to clarify where it seems to me we are.

With that, let's take a coffee break.

(Whereupon, a recess was taken.)

DR. MYKLEBUST: Now, may I call you to order again? May I reflect that I think the discussion has been most exciting and basic. Corrine and I were just comparing notes, and we don't know of a session -- perhaps some of you do but we don't -- that really concerned itself with the problem of the children who have more than one handicap.

So I suppose we shouldn't assume that we are going to be able to come up with a lot of answers today, but it is very interesting that we might be plowing quite new ground.

And I say right now at this point that I hope that sometime in the future we might have a session, perhaps at one of your centers, where we would give consideration to this problem alone, further consideration.

Obviously we are very much involved in it today in this conference. I think discussion is going along extremely well. Very basic issues are being raised, issues which certainly didn't occur to me. I think they are very important.

Several of you have made some observations now in our little break that I thought we might start with.

Frank, do you care to make your observation here for the group that I thought was very helpful, if we could start off again with that?

DR. HEWETT: Regarding the learning disabilities?

DR. MYKLEBUST: Yes, and germane to this if you would.

DR. HEWETT: I think one of the most important things that we accomplished with this learning disability definition is the sort of preservation of an educational relevance. And if there was any way to denote this or to sort of capture this relevance in a phrase or description referring to a number of disabilities, it would just be beautiful.

I just don't know how you can do this. This is the thing. I don't know how you can do it without using a small paragraph. But I think that was what was so significant about yesterday's work. And it's too bad we couldn't aim for that kind of relevance, educational operational relevance.

The "multiple handicap" is so cold and physical and kind of removed. If there was some way to get this relevance involved, I think it would be ideal.

DR. MYKLEBUST: I think the point is very well taken. Corrine, do you want to read that for us and tell us what it is, please?

DR. KASS: Here is a definition that someone slipped to me. Children with multiple handicaps are those who require a combination of special education services which takes into account the particular handicapping conditions.

DR. MYKLEBUST: Now, this is not to cut off discussion of anything, including more discussion of basic concept. But we did have this definition we wanted to call your attention to, in case we wanted to try to do what Frank is suggesting. I agree maybe we can't, but it certainly would be very interesting to try to do it in the next hour.

DR. BLAIR: I wonder if we could build on Sam's basic definition?

DR. MYKLEBUST: That's right.

DR. BLAIR: I have added just a bit to it. I haven't finished it. But the multiply-handicapped-- Maybe we should do what we did yesterday and not say "children with." But a multiple handicapped-- No, I'm not phrasing this properly.

Let me start off with Sam's exact wording.

The multiply-handicapped are those having more than one disability each of which would require special education. These conditions should be viewed in terms of the interactional effects on learning -- this is a term that someone else used -- rather than the additive effect let's say.

This is as far as I have gone with this.

DR. MYKLEBUST: Now, I think these suggestions are excellent. And along the line of this one, we are talking about those who are unable to learn by ordinary instructional methods. Then we get to this cold term that Frank talks of -- because of multiple involvement, and so on. If we could get away from that-- But I suppose what we are all saying here is these youngsters are not able to profit in the usual sense. Sometimes you say "profit normally." I don't like this term either.

But they can't profit by the ordinary instructional methods, which is basic to this one, for these reasons. Now, who wants to take it from there and see what-- I think it's very interesting to explore for the next hour if we could. I think it would be a very real contribution.

Go ahead, Corrine.

DR. KASS: One concept that has occurred to me has to do with the special services, the fact that handicapped children cannot profit from regular instruction. So one of our key phrases is "requiring the special education techniques."

It seems to me that we are talking about something even more than special education techniques in the traditional sense, and we are talking about a sort of multi-special education. It's still special education, I'm sure, but we are talking about something a little more than over and above regular education that is sort of one step removed.

DR. MYKLEBUST: Yes. And I think Frank has something of that in what he has there -- the concept that we really spelled out a number of things after we said it here. We could do the same. As Frank too has indicated, you don't add these up. It isn't part of any given regular program but something different.

DR. KASS: Or not even a part of a regular special education program.

DR. MYKLEBUST: Fine.

DR. ASHCROFT: Would you read the one you read again?

DR. KASS: Children with multiple handicaps are those who require a combination of special education services which takes into account the particular handicapping conditions.

DR. ASHCROFT: Frank's definition could be used as some of these ways of defining terms. Maybe the interactional idea could be used in defining, say, combination of special education services.

DR. RIDGWAY: I like the point that was made earlier that if you have a blind deaf child -- and maybe it was made just in conversation at the break; I don't remember -- but if you are going to teach him to read, you need to consider him as a blind child, while if you are going to teach him to communicate you can teach him as a deaf child, and that you don't have anything that is primary here but you have to plan a program that is based on the particular combination of problems or deficits.

DR. DENO: But you can't teach him to read just as a blind child either, because an ordinary blind child would have a verbal symbol system already present which he calls upon in the reading. So it becomes a recognition thing.

Whereas with the deaf it becomes a development of language concepts along with the reading.

DR. ASHCROFT: Yes.

DR. RIDGWAY: It's not in the least simple, and I didn't mean to infer that, but you have to change positions is what I'm getting at. You can treat him as a special case of a blind child one time, but you have to treat him as a special case of a deaf child another time.

MISS TAYLOR: But actually it is even more than this, because there is such a great degree of difference in hearing loss among those called deaf blind today.

There are I think extremely few who are blind, educationally blind, but there is a great variation in the visual loss.

So that even the method that you use in language development, or when that has been acquired some teaching of reading, varies from child to child to a great degree if you take that particular group.

Am I correct in this from your experience at the California school, for instance?

DR. HATLEN: Yes. This phrase "a combination of special education services" has a connotation to me of a number of specifically trained individuals working with a child. And I felt we were getting more at an individual who has some background in a variety of areas that can work with these kids.

I don't see it as a combination of services, at least in this respect, talking about deaf blind kids.

DR. MYKLEBUST: Well, Phil, could we focus now on not the person doing the work or not the individual variations in the population, which are going to be and always are tremendous, but rather on the population? Could we focus a little bit on this question Frank has called to our attention here, the population as a group?

Is there some way in which we might agree as to what this group or how this group should be designated?

We all feel that the "interrelated" terminology leaves much to be desired. It is, of course, one way of doing it. It might work. But we think it isn't very helpful. I think there is agreement about that.

We all have misgivings about the term "multiply-handicapped," "multiple involvement." Phil says he can't think of a better term. I think that it is true it was probably first very much developed through the field of physical handicaps.

Do you want to consider just the term "multiple handicap" for a little while and alternatives? How shall we designate this population? I think it will have a lot to do with how this group gets attention, this group of children, including training programs.

DR. DENO: Is it possible that we could do essentially what we did yesterday? It seemed yesterday before we were able to get together and put down a definition we came to a consensus about certain parameters that we agreed on that were limiting to the definition. And then we just got the words to put into the definition to define those parameters.

DR. MYKLEBUST: Yes.

DR. DENO: That's essentially what we are doing here when we are saying now or are establishing one parameter that when multiple defects are present in a child these deviations interact to affect learning and development in ways which are unique to each case, and they are not additive, or something like that, whatever you want to put in.

Well, are there some more that we could establish that are important to a definition? And then this might lead us to a term instead of starting with "multiply-handicapped."

DR. MYKLEBUST: All right. Interesting suggestion.

May I ask: Could we take this off the slate? I asked the man to leave it on last night in case we needed it. Do we need it anymore this morning?

(Erasing blackboard.)

Taking Evelyn's approach, let's see what we come up with as parameters. What do we think this should cover?

Evelyn, will you take these one at a time and see what we get before us? I think this explanation here would be very useful. If it comes up with something, fine. If we agree that we want to leave it and come back to it some other time, that's all right too.

Now, Evelyn, do you want to start us off?

DR. DENO: Well, these are the words I used, and I already see troubles with the words, where other words might be used.

But the idea was when multiple defects are present in a child --

DR. FLIEGLER: Do you want me to write it out? I thought you wanted parameters like you said yesterday?

DR. DENO: I don't know how to state it except in a lot of words. I can't state it in one word. Maybe somebody can think of it.

But when multiple defects are present in a child, these deviations interact to affect learning and development in ways which are unique to each case.

DR. MYKLEBUST: How about just "which are unique"?

DR. DENO: Yes.

DR. FLIEGLER: Did you say multiple "defects" or "handicaps"?

DR. DENO: I said "defects," but if you use "handicaps," that implies you are already making a functional determination, which makes it a better word.

Produces unique effect. And that's getting to the

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point that we don't think these things just add up.

DR. MYKLEBUST: On development and learning?

DR. DENO: Learning and development.

DR. MYKLEBUST: You want learning and development? Excuse me.

DR. DENO: It doesn't make any difference.

DR. FLIEGLER: Guide me.

DR. DENO: Development and learning.

DR. FLIEGLER: (At the blackboard) Produces a unique effect on development and learning.

DR. MYKLEBUST: Sam, you had something?

DR. ASHCROFT: I was going to suggest maybe "impairments" for "defects." I don't know if that adds anything or not.

DR. MYKLEBUST: Let's get all the terms up there.

DR. DENO: Yesterday we took "defects" out and put the word "handicaps" in deliberately, because the word "handicaps" implies that a functional determination has been made that this has a disabling effect. So it is a useful term for that reason.

DR. MYKLEBUST: That's right.

DR. FLIEGLER: Do you want "handicaps" up there too?

DR. DENO: Yes. Because "defects" always bothers me, you know. I think that all children vary in their learning proclivities, and just because they learn better visually than they do auditorially, should you say it is an auditory defect?

DR. MYKLEBUST: Now, if you don't mind, I'll just call on individuals here that have been writing something.

Frank Blair, you have something?

DR. BLAIR: Well, I have just been trying to put this together. "Multiple handicap" refers to a condition of disability in which a combination of factors impede learning. This condition should be viewed in terms of the unique interactional effects of these factors on the process of learning. The educational requirements of children with multiple handicaps -- blank, blank, blank.

DR. MYKLEBUST: The parameter there would be --

DR. FLIEGLER: Special education techniques? Services? What's your preference?

DR. BLAIR: I think in view of what we were doing we would have to bring in special educational techniques required should reflect-- I think we want to reiterate the idea of interactional again, but I'm not sure how.

DR. HEWETT: Combination of special education techniques.

DR. DENO: Well, the unusualness of the special education techniques required will be conditioned by the deviation that is produced by these interactional effects.

DR. BLAIR: Not conditioned. Governed.

DR. DENO: In our original definition on learning disabilities, a basic parameter in here was that these children required special educational techniques which it was not feasible to supply in the ordinary program of instruction. That was a basic criterion in here.

It seems to me that in this one now we are getting to a criterion within the special education organization that these children -- that the interactive effect of their multiple handicaps produces an accommodative need which is not possible -- which is not feasible -- to achieve in the regular program systems built around single disabilities.

That is the cutoff, but I don't know how you say that in one word or two.

DR. MYKLEBUST: Yes. To start with, we won't try to, Evelyn. Just so we get it down.

DR. FLIEGLER: Special education techniques required-- Beyond program systems?

DR. DENO: Beyond program systems which are satisfactory for children with -- what?

DR. FLIEGLER: Which are satisfactory in special education classrooms or --

DR. MYKLEBUST: Are present I think you mean. Which are used now.

DR. DENO: As presently stated, or whatever.

DR. MYKLEBUST: Yes.

DR. DENO: We know what we mean.

DR. BLAIR: Currently exist.

DR. SELZNICK: Presently provided.

DR. FLIEGLER: For children with single disabilities?

DR. DENO: Around assumptions regarding single disabilities.

DR. MYKLEBUST: Fine. Phil, go ahead.

DR. HATLEN: I would like to go back to Sam's definition, because I think there is a very important part of this which we don't have so far, and that is that each of these in and of itself requires, would require, special education techniques.

We were talking about this this morning. You work closely enough with exceptional children, with handicapped children, and you can identify multiple handicaps in all of them. But a good number of them don't really need this kind of unique service.

I think the parameter that Sam has in his definition is a very important one. It is if this additional handicap or more than one would of itself require special education services.

Thinking about rubella kids, you know, the ones with as far as we can determine almost normal vision, we feel that they could be served in programs for the deaf.

MISS TAYLOR: But they don't.

DR. HATLEN: But they don't.

DR. MYKLEBUST: Let's come back to this. I thought we were getting away from this for this reason: That I think we have agreed that here is a youngster -- and I'm illustrating -- with only a straight-across audiogram of 35 decibels, using the old system, not the new ISO system, which would be 45. But say 35 decibels. Now, this youngster has a learning disability rather severe. Neither of these alone would put him in special education. It is the fact that he has both of them that puts him in special education.

I think then that what Sam has here is very important -- that each of them might require special services in itself.

But Evelyn's point is, and I think part of Bill Wolfe's point is, that you have another group of children that you wouldn't pick up at all that way. You would include here children who because they have more than one involvement require special education, not either one alone. Is that right?

DR. DENO: That's right.

MISS TAYLOR: I think Phil has just brought this out in pointing out the children who seem to have practically normal vision --

DR. MYKLEBUST: Yes, he has.

MISS TAYLOR: -- are not acceptable to a program for the deaf, you see.

DR. MYKLEBUST: That's right.

MISS TAYLOR: Actually, if you view their handicaps separately, they would not possibly go into two separate special education programs, but the combination makes it different.

DR. MYKLEBUST: This is very good. So under No. 3 how does this approach it? Some of these would require special education services in and of themselves. Each of them in and of themselves. Others require special education services because of the -- here we are -- more than one, see, multiple, more than one, involvement, combination.

All right.

DR. DENO: Because of multiple interaction effect.

DR. MYKLEBUST: That's the idea I'm trying to get to.

DR. RIDGWAY: Are you saying that No. 3 would come first but there is another group who --

DR. MYKLEBUST: That's right, Bob, only I was putting them both in No. 3. I don't know if that's the way to do it.

DR. RIDGWAY: Haven't we done this in No. 1? What I'm saying is No. 1 now moves under No. 3 as the second half.

DR. MYKLEBUST: Could be, yes. But I agree with Phil on this point of Sam's that a lot of these-- Yes, either one alone would require special education. I think this is a good criterion.

I think it is also important that we include a group of children where one of the handicaps wouldn't require special education but the two together do, the two or more together do.

I think this is a very important group, yes.

DR. WOLFE: I have tried to borrow or have borrowed from everything that has been said here, and I have tried to come up with this definition:

The term "multiply-handicapped" refers to those individuals with a combination of problems or deficits each of which may require special educational techniques. When these multipl deficits exist, they produce a unique interrelated effect on development and learning and therefore require unique combinations of special educational approaches.

DR. MYKLEBUST: Well, Bill has said a lot here for us. That's a lot of what we are talking about, isn't it?

DR. WOLFE: It is nothing new. I borrowed from everything else here.

DR. MYKLEBUST: I'm going to ask Bill to read this again and see whether we have these parameters in and whether we are ready to start looking at a definition like this in more, well, specific terms, not final terms.

Will you note, all of you, whether we have these parameters included? And we could move on from that.

Bill, go ahead.

DR. WOLFE: The term "multiply-handicapped" refers to those individuals with a combination of problems or deficits each of which may require special educational techniques. When these multiple deficits exist, they produce a unique interrelate effect on development and learning and therefore require unique combinations of special educational approaches.

DR. MYKLEBUST: Frank Hewett, we are using the term "multiply-" here. Do you want to comment? What do you think about it in this connection?

DR. HEWETT: Well, I think it probably not going to do us too much good if we just get hung up on the label itself.

I don't know whether "multiple disabilities" or "the multiply-disabled child" is any closer to education than the "multiply-handicapped" and whether we could use-- I tend to like it a little better, but again I think it's too close to "learning disabilities" perhaps.

DR. MYKLEBUST: I think I'm right you're using the term "multiply-handicapped," Bill?

DR. WOLFE: I personally do not like the term "handicapped." I never have.

DR. MYKLEBUST: It's very difficult to get away from though, isn't it?

DR. WOLFE: You could say the "multiply-involved" or "a child with multiple problems," something of this sort.

DR. RIDGWAY: How about "multiply-impaired"? We have said visually impaired, so "multiply-impaired."

One thing I'm thinking about in the definition is that we must be careful that a youngster with two or more learning disabilities as they were defined yesterday would not be included under this definition.

DR. MYKLEBUST: Yes. We have to watch that. I think you're right.

"Multiply-handicapped." Okay. That's one way. "Multiply-involved." "Multiple deficits." The term Bill is using, the phrase, is "the term 'multiply-handicapped.'" "The term 'multiple deficits."

Bob suggests "The term 'multiple impairment' refers to."

Any preferences here or other suggestions?

DR. WOLFE: I start out using "multiply-handicapped" and then in the second sentence I say, "when these multiple deficits."

DR. MYKLEBUST: Yes, I like that myself. But any other comments on the leadoff here? Yes, Jo?

MISS TAYLOR: I like "multi-handicapped" because the dictionary does not have a prefix "multiply-." There is "multi."

DR. MYKLEBUST: It has "multiple" though.

MISS TAYLOR: "Multiple" but not "multiply-."

DR. MYKLEBUST: "Multiple" is the preferred term. This is quite right, Jo.

That is a good correction. I think "multiple" would be the preferred term. Actually it is the only term, as Jo points out. I think that's right.

MISS TAYLOR: "Multi."

DR. MYKLEBUST: Yes, but that's a little unwieldy here, isn't it -- multi-handicapped?

DR. SELZNICK: May I throw out another possibility?

DR. MYKLEBUST: Yes.

DR. SELZNICK: One of the reservations I think some of us may have is that this statement has a connotation for other than educational purposes. We have come to identify the word "handicap" et cetera.

DR. MYKLEBUST: Yes.

DR. SELZNICK: Now, what if the statement were something along this line: In some children one will identify-- And then-- I had it in my mind a few moments ago. So that it focuses on the child and his response to learning situations rather than the emphasis on the word "handicap."

DR. MYKLEBUST: Well, again I think the point is very well taken here. What do you think about "multiple involvement" or "multiple impairments" to get beyond this point, Harrie?

DR. DENO: I like the word "impairment." I think it is consistent with what we say in the others -- vision and hearing impairment.

And also to me the term "impair" has a connotation of function in it like "handicap" does too, because in some measurable kind of way there might be deviation there, but the

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word "impair" implies that it is interfering with something.

DR. MYKLEBUST: Yes.

I wonder, Frank Hewett, would this term "impairment" be more acceptable in the emotionally disturbed.

DR. HEWETT: We don't normally think of emotional impairment.

DR. MYKLEBUST: I know. That's why I'm concerned.

DR. HEWETT: Social impairment? Emotional impairment? Learning disabilities too. Impairment is maybe more related there. We are thinking of perhaps neurologically based impairment. It's very difficult, and I don't think probably it should be held up because these more functional social, emotional areas don't tend to be contained in the same nomenclature.

DR. MYKLEBUST: I sense we really feel "handicapped" isn't the best term here. "Involvement" is probably too neutral and doesn't really tell us very much. "Impairment" seems to be preferred. We don't want "multiple disabilities," do we? Because then we fall right into the learning disability one, don't we?

DR. BLAIR: Yes.

DR. MYKLEBUST: You see, I suspect then we are in trouble with what we did yesterday.

So we narrow down to "multiple impairments" then, do we?

DR. RIDGWAY: Will this communicate with the field all right? You know, if there are laws already on the books that talk about "multiple handicaps" or things like this, then just because a group of a dozen or 15 of us get together and make up a new term doesn't really mean much.

DR. MYKLEBUST: That's right. It can delay action on the part of our recommendations for years of course.

In this State-- Am I right? Let's see. No one can check me here. Jim, you can. In our State I think it is "multiple handicaps." I'm pretty sure it is -- the terminology.

DR. HEWETT: These are handicapped children and youth in Washington? This whole batch of youngsters?

DR. KASS: Handicapped children.

DR. HEWETT: I just wonder, Corrine, do you think that is important to preserve that kind of a consistency?

DR. KASS: [illegible] might be a point.

DR. SELZNICK: What about "multiple deficits" which we used in the earlier definition?

DR. MYKLEBUST: It comes in the second part of what Bill has. We could change that, Bill, so the initial could be changed, and you could change your second part when we start working the rest of it.

But "multiple deficits" also tends to overlap with yesterday to some extent.

I'm going to ask Bill to read that again to see how "multiple deficits" is used.

Go ahead, Bill.

DR. WOLFE: You mean the second sentence or all of it?

DR. MYKLEBUST: Read the whole thing again.

DR. WOLFE: As I had it originally? I have not changed it. If I were to change it to "impairment," we are going to have to change then the rest of it, because we are referring to individual --

DR. MYKLEBUST: No, read it the way you have it.

DR. WOLFE: The term "multiple handicap" refers to those individuals with a combination of problems or deficits each of which may require special educational techniques. When these multiple deficits exist, they produce a unique interrelated effect on development and learning and therefore requir unique combinations of special educational approaches.

DR. MYKLEBUST: Now, you see, there are several terms used there, "deficits" and "multiple involvement" I believe.

Now, there is a question here again whether we want to preserve the term "handicap."

Harrie, would you have serious objections to preserving it here?

DR. SELZNICK: No.

DR. MYKLEBUST: I said I agreed with Harrie. I have no serious objection to preserving it. I think the point is well taken here that there might be considerable delay in our separating ourselves from the term -- I mean delay in terms of accomplishing services and so on.

So what do you think? Is the term "handicap" here the best we can come up with?

DR. BLAIR: I think we should leave it.

DR. WOLFE: In view of the Office program, I think we should, though I don't like the term.

DR. MYKLEBUST: It seems, doesn't it, Bill, it is very difficult to get a better one?

DR. WOLFE: I think we should tie it in with the Federal program.

DR. ASHCROFT: I do like the term, because there are impaired children I don't want to work with. I don't want to work with them unless they are handicapped.

DR. MYKLEBUST: I see your point.

Evelyn made a point a while ago that "handicap" is a functional determination.

DR. WOLFE: It's a very negative term though. It's unable, below par, not up to snuff. It's all negative.

DR. BLAIR: But isn't that what we're talking about?

DR. WOLFE: I'm talking about the effect this term has upon the person who has the problems.

DR. MYKLEBUST: You always run into that, of course, after a term is used a while.

DR. HATLEN: Frank, do you use the term "emotionally handicapped"?

DR. HEWETT: I don't. I use "emotionally disturbed." Eli Bauer tried to put "emotionally handicapped" in the books because he felt "emotional disturbance" tended to make it look like the kid was upset with behavior problems rather than a kid whose emotions were handicapping him.

DR. MYKLEBUST: I think that's favorable though -- that the term "handicapped" has been used in emotional disturbance. It's favorable to our point here.

DR. HEWETT: That's right.

DR. DENO: I don't think we gain enough from changing from "handicapped" to do it.

DR. MYKLEBUST: No. It seems that we are really not gaining very much. Are we?

We will then proceed with the rest of this, and I would like to start having this on the slate now, because we are going to have to look at all these words, Bill.

Lou, would you help us again, please?

Evelyn, do we have this down? Because we are going to have to see if we have to make changes here to include the parameters here.

DR. WOLFE: The term "multiple handicap" refers to those individuals with a combination of problems or deficits each of which may require special educational techniques. When these multiple deficits exist, they produce a unique interrelated effect on development and learning and therefore require unique combinations of special educational approaches.

DR. HEWETT: Do you think that "producing unique inter-related effect on development and learning" should come in the first sentence and "requiring special educational techniques" in the second?

When these multiple handicaps exist, they may require special educational techniques. In other words, --

DR. WOLFE: I see what you mean.

DR. HEWETT: Is one more basic to the definition than the other?

DR. WOLFE: Yes.

DR. RIDGWAY: I think you can take out the qualifying business too -- "when they exist." We are saying there is such a thing, so we don't need the "when" part. Take out "when. Capital "T" on "these." Knock out "exist" and "they."

DR. ASHCROFT: Does this handle the combination of problems that wouldn't meet the criteria for special education services in and of themselves? You see, the "these" refers to "each of which requires."

No, I guess it refers to "problems" or "deficits." But this doesn't seem to handle that child who should be included even though neither or any of his problems meets the criteria.

DR. WOLFE: You could take out "these" then, Sam.

Just say, "Multiple deficits produce a unique interrelated effect." Wouldn't that handle what you are saying?

MISS TAYLOR: Yes. I wonder if we might not consider taking out "combination of," too, and just say "require unique special educational approaches." It may be something besides combinations of.

DR. MYKLEBUST: Go ahead, Bob.

DR. RIDGWAY: I was wondering if in order to make certain that this can't be confused with learning disabilities it would be helpful in the definition to stick in a parenthetical phrase after "problems or deficits" and put in something about, say, mental retardation, blindness, and so on, in parentheses.

DR. MYKLEBUST: "Such as"?

DR. RIDGWAY: Yes, in order to make certain that everybody knows we are talking about categories, --

DR. MYKLEBUST: Yes.

DR. RIDGWAY: -- rather than the things we were discussing yesterday.

DR. MYKLEBUST: All right.

DR. RIDGWAY: Another problem that I have is this "unique interrelated effect." I don't see this as quite the thing we were talking about earlier. I mean the term "interrelated" doesn't mean the same thing to me as --

DR. DENO: Interactive.

DR. RIDGWAY: -- as "interaction."

DR. WOLFE: I was using "interrelated" there to support the program, because you have to have something to tie that onto.

DR. BLAIR: Could we put another one on the board and look at it? Would this be appropriate, Mr. Chairman? Or do you want to work on this one?

DR. MYKLEBUST: No, we can modify and have combinations, Frank, like yesterday. We had three or four to work from. And I think there are others here that have other suggestions. Bill's I think was the most definitive statement that we had, and we got started on this.

But, as yesterday's, I think we all assume we may have to add and delete and so on.

Do you have one there now, Frank, that you finished?

DR. BLAIR: Yes.

DR. MYKLEBUST: All right.

DR. BLAIR: Do you want me to write it?

DR. FLIEGLER: That would be easier.

DR. ASHCROFT: While he's doing that, an idea was developed yesterday that I think was important. That is the concept of educational planning. I think so often we tend to think in terms of only a special class kind of provision instead of a broader concept of special education services that would be implied by special education planning.

DR. MYKLEBUST: Right.

DR. DENO: I have that down kind of as a fourth parameter, though we didn't write it.

Since the effect is unique in each case, the educational plan for each case is unique.

DR. FLIEGLER: The question I would have is: Do we really mean the word "unique" or "different" or "unusual"?

"Unique" refers to that rare quality, one of a kind. Are we getting ourselves into a bind there, you know?

DR. DENO: That was literally what I mean. That is why I used it. But maybe that's not appropriate. Because I think at least with the kind of children that we get falling out of what we were talking about here, the standard systems which we have developed, each of those kids stands out very idiosyncratically.

DR. MYKLEBUST: Yes.

DR. DENO: I can't think of them in a cluster like I think of visually impaired kids and hearing impaired kids. They are just so different. They are such an accidental combination of factors.

I think that is one of the reasons we have trouble providing for them. And when we do provide for them, it is usually, like Sam said, in some special center where we really have drawn together a wide variety of services so that we can organize it around the uniqueness of each case. Because at this point we haven't developed a curriculum for teaching really to deaf blind, have we?

DR. HATLEN: No. I don't think we want to.

DR. DENO: I don't think it would be worth it, because I don't think there are enough of them.

MISS TAYLOR: We keep attaching on for the multi-, multiple handicap because "deaf blind" doesn't really describe it.

(Reporter's Note: The statement placed on the board by Dr. Blair follows: "'Multiple handicap' refers to a condition of disability in which a combination of factors impede learning. This condition should be viewed in terms of the unique interactional effects of these factors on the process of learning. The educational techniques for children with multiple handicap must reflect the need for special programming which extends beyond that which is usually provided for a single disability.")

DR. MYKLEBUST: Thank you, Frank.

If I could just call your attention to-- Or, rather, I think Corrine has something to call your attention to here. But, first, Corrine, I will just read that. All right?

"'Multiple handicap' refers to a condition of disability in which a combination of factors"--

We already think that term would have to be "deficits, Frank, because it leaves it too general perhaps.

". . . of deficits impede learning. This condition should be viewed in terms of the unique interactional effects of these factors on the process of learning. The educational techniques for children with multiple handicap must reflect the need for special programming which extends beyond that which is usually provided for a single disability."

Now, there are several parameters here that we have looked at this morning.

Now, Corrine, do you want to take that first sentence or whatever you want to --

DR. KASS: I think we might be able to take a combination of the two again and come up with a simple first sentence, and then with our elaboration, which would be something like:

"Multiple handicap" refers to a combination of deficits which impede learning and requires special educational techniques.

I was trying to get the "interactional effects" in here.

DR. MYKLEBUST: But you see the approach Corrine is suggesting here.

MISS TAYLOR: The interactional effect of which requires.

DR. KASS: Combination of deficits which impede learning.

DR. DENO: The interactional effect of which impede.

DR. KASS: The interactional effect of which requires special educational techniques. And then we must go on to define these.

DR. MYKLEBUST: Jo, would you write that in as one sentence?

MISS TAYLOR: You wouldn't be able to read my writing.

DR. MYKLEBUST: I mean --

DR. RIDGWAY: We might --

DR. MYKLEBUST: Excuse me, Bob. Go ahead.

DR. RIDGWAY: I'm sorry. I was the impolite one.

DR. MYKLEBUST: Go ahead.

DR. RIDGWAY: I was suggesting to get Sam's notion in here that we say "the combination of which or interational effects of which" and then go on with the rest of that, get it all in the basic sentence.

DR. MYKLEBUST: It sounds good to me. Jo, would you get all of these down? Can you? And read them back to us here? Or, Corrine, do you have them?

DR. KASS: "Multiple handicap" refers to a combination of deficits which impede learning, the combination of which or the interactional effects of which require special educational techniques.

The combination or interactional effects. I don't think we have to say "of which" twice.

DR. RIDGWAY: No.

DR. KASS: The combination or interactional effects of which require special educational techniques.

DR. MYKLEBUST: That's progress, isn't it? That's a pretty good first sentence. It may need some further work, but it is combining various aspects of what we are talking about I think.

DR. WOLFE: It does leave out the point that Sam was making originally -- that each one of these alone would qualify for special education.

DR. MYKLEBUST: Yes. Presumably this has to be followed up. Then we go on now.

DR. KASS: We should define "combination" and we should define "interactional effects." In other words, that sentence would come under defining "combination of deficits" and then the interactional effects would be defined as the unique --

DR. MYKLEBUST: Yes. I don't like to take these off the slate, because there are several phrases here that might help us in further definition, like "usually provided for in a single disability," "special programming," and "combination of special education approaches." But we need these before us. Do we have these down so we could start over again, so to speak, and get some of this put together up here?

Do we have it down? All right, Lou. I think Corrine has the first sentence here. Do you want to read it for us, Corrine?

DR. KASS: "Multiple handicap" refers to a combination of deficits which impede learning, the combination of interactional effects of which require special educational techniques.

Now, we should define "combination of deficits."

DR. HATLEN: Would "planning" be better than "techniques"?

DR. DENO: Or "programming"? And how long can the sentence be? Because you could go on and say "programming beyond that required for children with a single disability" and run it all up in one sentence.

DR. MYKLEBUST: Let's try it. Would you put the other terms up there, Lou?

Special education program.

DR. DENO: Planning.

DR. HELLER: Services.

DR. MYKLEBUST: Planning.

DR. KASS: "Services" is good.

MISS TAYLOR: Services.

DR. MYKLEBUST: Now, Evelyn, go on from there, please.

DR. DENO: Beyond that required for the education of children with a single disability.

DR. RIDGWAY: You had better say "handicap" here instead of "disability."

DR. MYKLEBUST: Let's put in "handicap."

DR. FLIEGLER: You said "programming," didn't you,

Evelyn?

DR. DENO: Yes.

DR. MYKLEBUST: Now, how should we proceed? Shall we stay with this statement now before we go on and define the terms? How does this statement come through for us?

DR. HEWETT: Pretty good.

DR. MYKLEBUST: Bob?

DR. RIDGWAY: I like the addition that was made on the other one -- combination of deficits, sensory, motor, emotional, or learning disability.

DR. DENO: In parentheses.

DR. BLAIR: That makes it a little bit long now, I think.

DR. KASS: We can put it under the definition of "combination of deficits," if we use this as the phrase to be defined.

DR. DENO: To follow the pattern we used in the one yesterday.

DR. HELLER: We can use that other combination though in the second line, because if you have interaction you have got to have a combination.

DR. HEWETT: Interactional effects of which?

DR. FLIEGLER: Is this consensus Texas style?

DR. HEWETT: How about it, Bill?

DR. WOLFE: Right.

DR. ASHCROFT: I think this is a new question, but I'd like to raise it. I'm wondering about other terms than "learning," such as "development" or "adjustment." Or is "learning" broad enough to cover everything we mean?

DR. DENO: We are trying to stay with the educational orientation, aren't we? Our special responsibility is to facilitate learning.

DR. RIDGWAY: We used "development and learning" before.

DR. KASS: That's good.

DR. FLIEGLER: Shall we just throw it in there?

DR. MYKLEBUST: Let's throw it in. Which impede development and learning. Sam, how do you like that?

DR. ASHCROFT: I think that's all right.

MISS TAYLOR: I'd like to put "unique" back -- require unique special educational techniques.

DR. ASHCROFT: We said "beyond that required."

MISS TAYLOR: I thought that would eliminate having that long sentence.

DR. SELZNICK: Do we really have two sentences there rather than one?

DR. MYKLEBUST: Excuse me, Harrie. Lou, did you have something?

DR. FLIEGLER: There was a suggestion on the "unique." Where did you want that, Jo?

MISS TAYLOR: Well, I think we should leave the longer phrase instead. I thought we could just cut it shorter.

DR. MYKLEBUST: All right then, Harrie. How would you divide that into two sentences?

DR. SELZNICK: After the word "learning," capital "T" on "the," and, "The interactional effects of these. . ."

DR. DENO: Of the combination of defects?

DR. SELZNICK: Yes.

DR. MYKLEBUST: Would you prefer to have this in two sentences is the question. And that would change No. 2.

Go ahead.

DR. KASS: We could keep it in one sentence if we said "which impede development and learning."

DR. MYKLEBUST: That's the way we have it.

DR. KASS: And producing interactional effects which require.

DR. MYKLEBUST: You'd have to have "which impede development and learning."

DR. KASS: Producing.

DR. MYKLEBUST: And produce.

DR. KASS: And produce. And produce interactional effects which require.

If we are agreed. We are agreed, aren't we, on the interactional effects and it should be part of this sentence?

DR. MYKLEBUST: Interactional effects which require special educational techniques.

DR. WOLFE: Is that "impedes and produces"? It refer to combination, doesn't it?

MISS TAYLOR: Yes.

DR. HELLER: Of deficits impeding learning and producing.

DR. BLAIR: It's the combination which impedes. Is that what you're saying?

DR. WOLFE: Yes. It should be "impedes" instead of "impede." Singular, isn't it?

DR. KASS: "Combination" is a bad word.

DR. BLAIR: "Impedes," Lou.

DR. HEWETT: And "produces."

MISS TAYLOR: "Combinations" would say it.

DR. KASS: Why couldn't we say "refers to interaction of deficits which impede development"? No, no good.

DR. DENO: Combination of interacting deficits.

DR. KASS: A combination of interacting deficits.

DR. HEWETT: Two or more deficits.

DR. DENO: We also said "a combination of interacting deficits" as a possibility.

DR. RIDGWAY: That negates the notion that all of the don't necessarily interact.

DR. KASS: That's right.

DR. MYKLEBUST: That's right.

MISS TAYLOR: I like the idea of having the "combinations." Because there are a variety of combinations that occur. And you can leave your "impede" the way it was.

DR. MYKLEBUST: "Refers to combinations." Take out "a." "Refers to combinations of deficits which impede." Take out "s."

"Which impede development and learning and produce interacting"-- Or "interactional"?

DR. KASS: Interacting.

DR. MYKLEBUST: Interacting. Which produce interacting effects requiring special education planning services-- Which require special education -- period.

DR. HEWETT: Don't we have to put something like "for remediation"? It's hanging there.

DR. MYKLEBUST: Yes.

DR. KASS: Yes.

DR. HEWETT: These effects are produced and require the techniques.

DR. KASS: "Services" would be all right, wouldn't it?

DR. HEWETT: "Services" would be.

DR. KASS: Services.

DR. HEWETT: The techniques to do something.

DR. KASS: I like "services."

DR. MYKLEBUST: Which require special education services. All right?

All right, Lou -- "services." Which require special education services.

DR. ASHCROFT: This is the field of multiple choice definition. (Laughter)

DR. HEWETT: Proceed in multiple choice. (Laughter)

DR. WOLFE: Are you going to leave that phrase at the end --- "beyond that required"?

DR. DENO: "Beyond those," then.

DR. WOLFE: "Beyond those" then.

DR. FLIEGLER: All right. I think we are ready for voting. Yes, Bob?

DR. RIDGWAY: The "produce interacting effects" could be changed, and we could say "and interact to produce effects." Isn't that what we are really talking about? These conditions don't produce effects. They interact.

DR. DENO: That's better.

DR. MYKLEBUST: Which interact to produce effects.

DR. DENO: Or "produce educational needs," if we want to get back to the education.

DR. FLIEGLER: Which interact?

DR. MYKLEBUST: And produce.

DR. HEWETT: Could you put "impeding" then to get rid of the "which"? The combinations of deficits impeding development and learning.

DR. CHALFANT: I'm not sure I'm reading this properly. Are we saying "multiple handicaps" refers to combinations of deficits? Now, I'd like to put something in -- "which interact and"-- Let's see.

"Which interact then and result in development and learning problems or produce. . ."

DR. DENO: Which interact.

DR. CHALFANT: In other words, put the "interact" right after the "deficits." It's the deficits that interact and produce this.

DR. MYKLEBUST: It's "interact and impede" -- "which interact and impede learning."

DR. CHALFANT: Yes.

DR. FLIEGLER: All right.

DR. MYKLEBUST: Which interact and impede learning -- impede development and learning and produce effects.

DR. DENO: Mike, don't they interact to impede rather than "interact and impede"? I mean the interaction produces the impediment. They interact to impede.

DR. HEWETT: Just "require special educational services." You get rid of the "which."

DR. MYKLEBUST: That's good.

DR. HEWETT: And which require.

DR. CHALFANT: And require.

DR. DENO: In ways which require.

DR. FLIEGLER: I just want to get these up here an then we can take our choices.

DR. MYKLEBUST: Now, we have deficits which interac to impede development and learning. Where are we?

DR. WOLFE: And which require.

DR. HEWETT: Which require special education servi

DR. DENO: "And" is always weak. Can we say "inte act to produce effects which"?

DR. MYKLEBUST: Interact to impede development and learning. That is what we have.

DR. DENO: In ways which require special education techniques.

DR. HEWETT: So that special education techniques required.

DR. MYKLEBUST: We don't have "in ways" up there. In ways which require special education services beyond thos Now, we can't use "require" again. Beyond those planned typically for children --

DR. BLAIR: Normally provided.

DR. MYKLEBUST: Beyond those typically provided, i you'd wish, for children with a single handicap. I think tha "beyond" is an important addition.

DR. WOLFE: That's good.

DR. FLIEGLER: There was something I lost here.

DR. MYKLEBUST: Which require special education services -- that's it -- beyond those --

DR. FLIEGLER: Okay.

DR. MYKLEBUST: -- typically provided for children wit a single disability.

DR. RIDGWAY: Handicap.

DR. MYKLEBUST: Now, Bob suggests that last word should be "handicap," and you see it's up there -- for children with a single handicap.

DR. FLIEGLER: May I suggest something?

DR. MYKLEBUST: Yes.

DR. FLIEGLER: If I may. Could we start backwards in a sense? We have a lot of suggestions up there, and that may be our problem. Are we comfortable with this phrase, "indicating"? Let's change just this phrase back here (indicating phrase beginning with "beyond."). I think you all agree it needs to be in there.

DR. MYKLEBUST: How would you do it, Lou? What do you mean?

DR. FLIEGLER: Well, do we want "handicap" or "disability"?

DR. HELLER: I don't think you're being uniform if you use "handicap" and/or "disability" there when you are using "deficits" up above. You are referring back to a deficit Why not call it a deficit?

DR. FLIEGLER: All right.

DR. HELLER: With a single deficit.

MISS TAYLOR: We are also calling it "multiply-handicapped."

DR. ASHCROFT: Can you work from the end without the antecedents?

DR. HEWETT: You have to start from the beginning.

DR. FLIEGLER: Your phrase won't change here. This is what I think everybody is agreed on. This is my suggestion. Everybody is talking about beyond that, beyond those typically provided. In other words, a word may change, but this from what I have been gathering here-- I don't know. Everybody agrees that this must go in.

DR. DENO: It's a criterion.

DR. FLIEGLER: That's right. It's one of the parameters. So all I am saying is it would be simpler for us to start just to throw this in.

Now, we can go back to it, but everybody feels this ought to go in.

DR. DENO: Lou, with respect to that, it seems to me yesterday too when we used the word that it "required" special education services this was an index. The word "require" was an index. So this also says in ways which require special education services beyond that.

And then we went to "typically provided," which is weaker because it doesn't say anything about requirement. It just says about what we ordinarily do.

DR. MYKLEBUST: Yes, I was thinking --

DR. DENO: So why don't we say "those needed for children with a single disability" or something like that?

DR. MYKLEBUST: We can use the word again. I was just trying to avoid redundancy.

DR. RIDGWAY: It's stronger to have "require" both places.

DR. MYKLEBUST: That's right. I'm sorry I suggested it. I think we should use "required" both places. Both places. Okay?

DR. DENO: Yes.

DR. MYKLEBUST: Beyond that required. Let's take out that "typically provided." I was just trying to get away from using the same word twice, and here you need it twice.

DR. FLIEGLER: Beyond that required -- or needed?

DR. MYKLEBUST: Required.

DR. KASS: Make it "those" to go with "services."

DR. FLIEGLER: All right. Beyond those. Beyond those required for children with a single -- disability, handicap, deficit?

DR. HEWETT: Handicap really. Doesn't it refer back to "multiple handicap"?

DR. FLIEGLER: Okay. Handicap.

All right. "In ways." Shall we leave that in? That' a qualifier.

DR. MYKLEBUST: Ways which require special education services.

DR. FLIEGLER: All right. In ways which require special education services.

Okay. Now we can I think go to the antecedents and play with that.

DR. RIDGWAY: Let's erase what we don't need over here now.

DR. FLIEGLER: Okay. What is it that we can agree on?

DR. RIDGWAY: Start with "require" and knock the rest of it out.

DR. FLIEGLER: Do you want "which" in there? Because we have "in ways."

DR. RIDGWAY: We don't need that.

DR. FLIEGLER: I will leave these terms up there because they might be discussionable (indicating terms "programs," "planning," "services," and "programming.")

DR. RIDGWAY: The interaction business can come out, because we have it earlier.

DR. HEWETT: Interactional effects.

DR. RIDGWAY: That can come out.

DR. WOLFE: Second line.

DR. MYKLEBUST: Would it help if we had Lou read this now? Lou, can you read it?

DR. FLIEGLER: Not really. (Laughter)

"Multiple handicap" refers to --

DR. KASS: Combinations. Erase the top.

DR. FLIEGLER: Okay. "Multiple handicap" refers to combinations of deficits which interact to impede development and learning and produce --

DR. HELLER: In ways.

DR. FLIEGLER: -- in ways which require special education services beyond those required for children with a single handicap.

DR. MYKLEBUST: Jim?

DR. FLIEGLER: Wait a minute. May I just get this down?

DR. MYKLEBUST: One moment, Jim.

DR. FLIEGLER: Which interact to impede development and learning. Okay.

DR. MYKLEBUST: Now, Jim.

DR. CHALFANT: Would this be grammatically correct -- I'm not sure -- if you omitted "in ways which" and put "and" there? I'm not sure when I read this whether it comes out properly or not.

DR. RIDGWAY: The notion was that "and" was a weaker word.

DR. CHALFANT: All right. I was trying to cut down.

DR. MYKLEBUST: Phil, go ahead.

DR. HATLEN: The term "beyond"-- Does that infer that we are saying that these services need to be something even more than we provide for other groups of handicapped children? Or do we mean different from those required?

DR. MYKLEBUST: This is a very interesting question, and I'd like some reaction.

My own feeling, Phil, was that the term was rather beautifully inclusive and could include all of this, that it's beyond-- I thought of it as something other than what we now do but it refers to what we do but something else in addition. So it is rather an innovation.

Now, some other reaction?

MISS TAYLOR: Yes. "Beyond" to me implies this idea I thought we were trying to get away from of building upon what we already have.

DR. MYKLEBUST: That's right.

MISS TAYLOR: Rather than developing something unique. And I would think that "other than" or something like this would be more appropriate to what we would hope to give these children.

DR. MYKLEBUST: Then you think "beyond" doesn't say it?

MISS TAYLOR: No.

DR. MYKLEBUST: I thought it was saying it very well.

Education services beyond, you see -- other than, in addition to and beyond.

Yes, Corrine?

DR. KASS: What about the phrase "services in addition to"?

DR. WOLFE: It's not necessarily in addition to. It's different from certainly.

DR. KASS: It might be.

DR. MYKLEBUST: Yes.

DR. ASHCROFT: I like "different."

DR. WOLFE: The word "unique" might have helped.

MISS TAYLOR: That's right.

DR. MYKLEBUST: This might be the term. I would just ask you. Does this mean now that you can't use anything of the other? I think "beyond" was something where you use what you had now but more. Go ahead.

DR. ASHCROFT: Well, there are those multiple handicapped children in disability categories who will be served in the category whose problems are not so different or so severe --

DR. MYKLEBUST: That's true.

DR. ASHCROFT: -- in such combinations that --

DR. MYKLEBUST: That's true exactly. You would use what, Sam?

DR. ASHCROFT: Different from.

DR. MYKLEBUST: All right.

DR. FLIEGLER: May I also go back to something that you have been reiterating that strikes a responsive chord? I'm not sure I can prove it.

That is, you talk about a psychology of learning, what I call behavioral science in special education.

DR. MYKLEBUST: Right.

DR. FLIEGLER: Then you made the point quite clearly that perhaps for these kids there is a new or different set of learning principles which we have to evolve.

DR. MYKLEBUST: I like that very much. Anyone else?

DR. DENO: Would it help to say "which require a special education services system different from those required for children with a single handicap"? That would allow you to bring in different combinations of things.

DR. FLIEGLER: Could we go back to what Sam said? I'm sorry. I didn't mean to interrupt.

DR. MYKLEBUST: Go ahead, Lou.

DR. FLIEGLER: The word "planning"-- Is this what you mean, Sam? See, this is an administrative term to some degree. Whereas "planning" is-- Is this what you were getting at, Sam?

DR. ASHCROFT: Not in this most recent comment, but earlier I was.

DR. MYKLEBUST: Jim?

DR. CHALFANT: I'm not unhappy with "services." Another word that might be used here could be "special education programming."

DR. DENO: We have got that over there.

DR. CHALFANT: Yes, it's over there.

DR. BLAIR: I think there is a point here about "services." You're right, Lou. It is administrative. It does have that connotation. And we are talking here about educational needs, which, of course, does involve services and so on, but we are talking about methodologies too.

DR. FLIEGLER: What's your pleasure?

DR. DENO: Does the word "accommodations" then give it to you?

"Instructional accommodations" or something?

MISS TAYLOR: How about "services and techniques"?

DR. BLAIR: Something like "approaches."

DR. MYKLEBUST: Now, "approaches" hasn't been up there Do you want to put it on, Lou, just to see how we come out here

Now, Frank Hewett stepped out, but you noticed a while ago he was objecting to "programming" and so on as not meeting some of the requirements of the children that we are talking about.

So I think we should see whether "services" did fill the need for some of this.

That was his opinion then. So I think we are shiftin emphasis in a way if we get off here. We would want to consider it carefully before we go ahead.

In ways which require special education programming systems, approaches-- Frank, we're getting away from a term you had. Help us out.

DR. HEWETT: Sure. I'm glad I came back in time.

(Laughter)

DR. MYKLEBUST: The term "services" is being questioned there, Frank. And you wanted "services" in.

"Programming systems," "approaches," or something else. But now "services" is being questioned. And you had a special reason for wanting "services."

DR. HEWETT: It was just it seemed if you didn't have "services," you needed something like "for remediation."

If these interactions impede development in ways which require special educational something for something, "services" was all-inclusive.

If it is "approaches" in order to do something --

DR. MYKLEBUST: Yes. Well, Jo is suggesting two terms. I'm afraid we're coming to two terms. Services and remediation or something.

MISS TAYLOR: Techniques.

DR. DENO: Yesterday we used the term "remediation" though to refer to disability which had the potential for correction.

DR. HEWETT: Can be corrected.

MISS TAYLOR: That's why I was using the word "techniques," because I think beyond the special services we also have to think in terms of special techniques.

DR. MYKLEBUST: Joe, I think "approaches" really says something too. Special education approaches and remediation?

MISS TAYLOR: And techniques.

DR. MYKLEBUST: You don't want two?

Okay, Bob.

MISS TAYLOR: I want two, but not the word "remediation," because we have used that so much with special education.

DR. MYKLEBUST: Excuse me.

DR. DENO: What about "special approaches to education different from those required to"?

DR. MYKLEBUST: Now I have to slow you down so you can each one come in on this.

Bob, you're next.

DR. RIDGWAY: I don't like the word "approaches," because this means you are getting close to something. And I think we want to hit it.

DR. MYKLEBUST: I see.

DR. RIDGWAY: "Services," as has been pointed out, and "systems" also are administrative terms.

"Programming" or "planning" are the two that --

DR. HEWETT: We kicked out "techniques," did we?

DR. MYKLEBUST: No, not yet.

DR. HEWETT: That's not up there.

DR. FLIEGLER: I'm sorry. I was objecting to "techniques." (Laughter)

DR. MYKLEBUST: Bob, are you through?

DR. HEWETT: "Instructional techniques" would be better, wouldn't it?

DR. RIDGWAY: I like "programming" or "planning," either, better.

DR. MYKLEBUST: One at a time, please. Bob likes "programming" and "planning."

DR. RIDGWAY: The "techniques" bother me a little, because there are things other than techniques involved, as we mentioned earlier.

DR. MYKLEBUST: Okay. Now Harrie.

DR. SELZNICK: I was leaning to "educational intervention."

DR. MYKLEBUST: Another term, "intervention."

DR. SELZNICK: And removing the word "special.

DR. MYKLEBUST: Bill?

DR. WOLFE: I don't like the word "remediation." Let me start back that far.

I had the opportunity to look up the word "remedy." Do we really know what that means? I was surprised to find out some of the meanings of that thing. It means to correct, reverse, and we are not going to do that with these kids.

DR. KASS: Right.

DR. WOLFE: So I think we have to throw that out.

I personally like "programming." It says that we have to give thought to producing something different. I would say "programming different from that required for children with a single handicap."

DR. MYKLEBUST: Now, if I could just for a moment-- Harrie,why do you want "special" out? Because of our trying to really relate this to special education-- I was wondering. Do we really want to consider this suggestion of Harrie's? Are we going to say "special" has a real place in this?

DR. SELZNICK: I'll tell you why very simply.

DR. MYKLEBUST: All right.

DR. SELZNICK: I think special education really is not easily definable. I think special education relates to an administrative package. It includes a number of related but independent, independently prepared and provided, services. I think that's about --

DR. MYKLEBUST: But we have a field of special education.

DR. SELZNICK: Yes, but I don't know what it means. I frankly don't know what special education means in a broad sense -- although I have devoted a life to it.

I am the Director of Special Education, but really it means something-- It means that I have a responsibility for a variety of programs and services.

DR. WOLFE: I move we pick up his cards. (Laughter)

DR. SELZNICK: That's all right. You'll be doing me a favor. (Laughter)

But I think it's a question we ought to be able to answer ourselves.

DR. MYKLEBUST: I think you're quite right in a philosophical sense. I wonder though if we don't jeopardize our intent and purposes by becoming too general here.

It would seem to me-- Corrine, you wanted to say something?

DR. KASS: No. I would agree. I think that our focus has been special education, and we have been saying these require something specific. So I think --

DR. WOLFE: It would seem to me for all of the single problems special education would have the responsibility, but when they get more difficult, in the area of the multiply handicapped, we are going to let just regular education take care of that.

DR. SELZNICK: No, --

DR. MYKLEBUST: Jim is next.

DR. CHALFANT: There are two ways you might look at this "special." You could look at it in terms of special education, which I think you are doing, or you might look at it in terms of special educational programming, special educational planning.

DR. HEWETT: It sounds like you can put them all on teaching machines if you have programming. I think that's a funny word.

DR. MYKLEBUST: Very much in that direction. Programming really does come into teaching machines.

Yes, Bill?

DR. HELLER: I like the word originally, "services," because if you work with multiple handicapped children I think you not only are working in a classroom situation but there are other administrative, organizational, planning -- everything that impinges upon this particular type child that may not on another. So it is a range, a broad scope.

I don't think we want to be exclusive here. I think we want to be a little more inclusive.

DR. MYKLEBUST: I think the comment is well taken.

Sam, you're next.

DR. ASHCROFT: Let me propose we say "in ways which require special education different from that required for children with a single handicap."

DR. HEWETT: You took all the fun out of it. (Laughter)

DR. MYKLEBUST: How do you like that?

DR. WOLFE: It takes us off the hook.

DR. HEWETT: In ways which require special education?

Golly. Does that follow?

DR. BLAIR: That's really broad now.

DR. DENO: That would have to assume that we agree that special education is a program of services so that we are using "special education" like a noun.

DR. MYKLEBUST: That's what we are doing.

DR. BLAIR: It seems to me we are talking about services. We are also talking about techniques. We have got to provide for both of these. And I think either word alone doesn't satisfy me.

DR. MYKLEBUST: Now, Frank Blair, you're saying you don't think you can leave out any-- What is it?

DR. BLAIR: No, it seems to me that we are talking as much about special techniques which may be provided in a variety of ways, perhaps within existing programs or perhaps in new innovative programs. And if we say "services," I think it suggests that there has to be innovation. And I'm not sure this is always true. I think we are going to operate many of these kids in current kinds of programs.

DR. MYKLEBUST: Now, I think we have all had a good chance to really explore this, and I must say that I see advantages to Sam's suggestion. I also see some disadvantages which Frank is emphasizing. I think Sam would be happy to go along with the group's decision if they want to put a word in here. I would be happy to go along with it.

I wonder if "services" -- if we put a word in -- isn't the one that most of us feel says what most of us mean. Can I ask the question that way?

I think the term "systems," "programming," and "approaches" have essentially here in our discussion been considered more limiting, hence not as useful.

And Harrie's suggestion-- Harrie, I think the group says they think the term "special" adds to it. I don't think you would be concerned greatly if we left it in as a designation, let's say, even though it may not fit with the philosophical concept that you are raising. It might be useful here.

I am trying to resolve our various feelings about this and raise the question this way: Could we agree that we leave "special" in, leave "services" in, and go on to further discussion of other aspects of this which will need looking at next?

DR. HEWETT: Is it appropriate to leave it just "special education" or should there be "special educational services"?

DR. MYKLEBUST: I was wondering about that, too. I think grammatically this is a little bit off, though it depends a little bit on how we are using it I guess.

Would you like "requires special educational services"

You see, Frank, that's a little different emphasis than what we were talking about. We were really talking about special education as a noun.

DR. HEWETT: Right.

DR. MYKLEBUST: And most of the time I think most of us have felt -- and that's what concerned me about this term "special" -- that we are relating this to an activity organized within our culture in the school systems, and it is this area of effort that we are talking to, you see -- in ways which require this area of effort --

DR. HEWETT: That's right.

DR. MYKLEBUST: -- to do something different from that which we do for children with a single handicap.

DR. HEWETT: "Special educational" can become an offshoot of something they do in the regular classroom kind of thing where this is identified with a discipline or --

DR. MYKLEBUST: That's the intent.

DR. HEWETT: Yes.

DR. MYKLEBUST: All right. Lou, let's take it out now and see-- We can always come back.

Now, we left off "instructional techniques." And you can take off those other words. Combinations of deficits which interact to impede development and learning in ways which require special education services different from those required for children with a single handicap.

I'd like to compliment you on a beautiful sentence, beautiful statement. I really think you have said a great deal.

I really do. I think it's a very nice statement.

Now, mind you, I am aware that we all compromise a little in these, but I think that this is a very good statement for many purposes for these children.

Shall we now consider what we do next? First, let's take another break.

(Whereupon, a recess was taken.)

DR. MYKLEBUST: Now, this is a very good statement. I really believe that we can't improve on it.

Well, there is the next step which I would like to suggest that we think about for the rest of the morning, and that is this: How might now this definition be interpreted? How can we as a group suggest that this definition be applied to help people working with the child who has both visual and auditory impairment or the retarded child who has visual impairment, and so on?

What are the implications here in terms of the people that are confronted with this problem?

To some extent now, if you like, we can talk about training. But I would rather first try to anticipate some of the many implications.

Bob Ridgway, do you want to comment on this?

DR. RIDGWAY: It seems to me the definition was made necessary because of the confusion that exists among all of us when we make applications for training funds and the confusion that existed on the panel knowing how to react to proposals.

One of the-- Well, I'm really not able to react to this very well without reference to training.

DR. MYKLEBUST: Yes. Well, we'll be happy to have you go on with that.

Corrine, go ahead.

DR. KASS: Well, may I suggest that where we might break this down into the various combinations is to take the phrase "combinations of deficits which interact" with a statement about the statement Sam made, each of which might require special education services, and the idea of interaction, and then take the various combinations of interaction and perhaps discuss each of these in turn.

DR. FLIEGLER: This is our clarification?

DR. KASS: Clarification and discussion of the combinations.

DR. MYKLEBUST: All right.

DR. DENO: Lou, you changed the last word when you rewrote that.

DR. FLIEGLER: I did? I'm sorry.

DR. MYKLEBUST: Now, Corrine is suggesting the approach we used yesterday -- that is, to go ahead now and say what we refer to, or, rather, something of what we indicate here.

So the first one that we take up would be "combinatio of deficits."

Corrine, could you take that?

DR. KASS: Yes. I would take all of it -- "combinations of deficits which interact" -- rather than breaking these apart, and then show that these might be two separate or three separate handicaps which could be dealt with in each of these ways or interaction of deficits and then provide examples of this by talking about the deaf blind, blind retarded, and interacting --

DR. MYKLEBUST: Yes.

DR. DENO: This would be the place we would bring in Bob's point before. That is, the deficits referred to include such as mental retardation, blindness. You know. You were talking about putting in that parenthetical statement in order not to confuse it with the combination of learning processes which we included under disability, learning disability.

DR. MYKLEBUST: All right, Phil.

DR. HATLEN: Maybe prior to this would come something like what was done yesterday, which was the second paragraph kind of elaborates on the term "learning disability," which isn't necessarily definitive, but it does elaborate on it. And maybe we need to elaborate on "multiple handicap."

I just put this down, and this can't be used because it is too much like this sentence in words. But "multiple handicap" refers to those children who are handicapped in more than one of the following areas -- and then just repeat the areas which were eliminated yesterday, sensory, motory, intellectual, emotional. And then include learning disabilities in that list. Because this would be one, too.

But this would come before what you are talking about I guess (to Dr. Kass).

MISS TAYLOR: It's the same thing, isn't it? Isn't that what you are saying? Just in different words?

DR. HATLEN: You're breaking them down even further, though.

DR. MYKLEBUST: Now, if I may, I would like to have these suggestions up there, Lou, if we can. Take Phil's. He has something before here.

"Multiple handicap" refers to what, Phil?

DR. HATLEN: To those children who are handicapped in more than one of the following areas.

DR. MYKLEBUST: "Multiple handicap" refers to children --

DR. HEWETT: If we replace "deficits" with "handicapping conditions," we could just take out "handicapping conditions" and expand it. You can't do it with deficits so easily.

But would that be easier? In place of "deficits" in the original put "handicapping conditions," and then go and say, "handicapping conditions" refer to -- because that is real what is essential here.

The "interacting and impeding" isn't essential to redefine, is it, or to include in a clarification?

DR. KASS: Well, --

DR. MYKLEBUST: All right, Corrine.

DR. KASS: In the first place, I think you are really starting another definition of "multiple handicap," which we already defined. In other words, the clarification comes into taking that part of the definition which needs elaboration and clarification.

DR. MYKLEBUST: I think this is the attempt here, yes.

DR. KASS: The suggestion I am making is that we have to take the combinations and interaction together because we are saying that the interaction is what produces another sort of child.

DR. RIDGWAY: I think what Phil is saying is that before you talk about combinations you need to know what you are talking about -- sensory, motor, --

DR. HEWETT: Deficits.

DR. RIDGWAY: Et cetera. Deficits.

DR. KASS: Well, the "combinations of deficits" is synonymous, isn't it? Synonymous with the various combinations? No?

DR. RIDGWAY: What I see is that the combination is deaf blind, et cetera, et cetera.

DR. KASS: Yes.

DR. RIDGWAY: But at least following your suggestion we would list what we mean by "handicaps."

DR. DENO: The deficits referred to are such deficits as blindness, deafness, mental retardation.

DR. RIDGWAY: Yesterday we said we are talking about things that are not included in sensory, motor, intellectual, and emotional problems. Now the suggestion is we are talking about combinations of sensory, motor, intellectual, et cetera.

DR. KASS: All right.

DR. RIDGWAY: We still have to do the thing you suggested -- talk about the combinations and their interaction.

DR. MYKLEBUST: Now, then, we are giving clarification of what a multiple handicap means.

DR. DENO: What kind of deficits we are talking about.

DR. MYKLEBUST: I just want to be sure I'm clear.

DR. HEWETT: It's the deficits that we first have to clarify. Isn't that right? Then the combination. That's the word that really is ambiguous there.

DR. MYKLEBUST: Well, then, you are saying-- That's what Corrine is saying, isn't it? I think we are not quite clear.

Yes?

DR. RIDGWAY: Phil, I think we'd clear this up if, instead of saying "'multiple handicap' refers," we say "'handicap' refers to" and then list the conditions. Then go to "combinations of deficits which interact," as Corrine has suggested, and explain this phrase.

DR. KASS: What you're doing then is redefining or defining in other words, "multiple handicap."

DR. RIDGWAY: No, --

DR. FLIEGLER: No, he's elaborating.

DR. RIDGWAY: Knock out the word "multiple."

DR. SELZNICK: And start with "handicap."

DR. RIDGWAY: "Handicap" in this sense refers to.

DR. BLAIR: Do you think that's necessary, Bob? It seems to me that's assumed, isn't it?

MISS TAYLOR: Why don't we use the thing where we --

DR. HEWETT: "Deficits" is the ambiguous word here.

DR. MYKLEBUST: One at a time. We'll let Bob finish. Bob?

DR. RIDGWAY: It seems to me that you can elaborate on "handicap" or you can elaborate on "deficit," either one. But Corrine had wanted to talk about the combination of deficits which interact.

DR. MYKLEBUST: Right.

DR. RIDGWAY: As a single term.

DR. MYKLEBUST: Let me ask you, Bob: Why do you think you have to put that in here? Why do you have to say something about what a handicap is?

DR. RIDGWAY: In order to differentiate between this definition and the definition of learning disabilities, so that nobody gets confused about this.

DR. MYKLEBUST: I see.

DR. RIDGWAY: If we are just talking about combination of deficits, this could be --

DR. MYKLEBUST: I see your point now.

DR. KASS: Oh.

DR. HEWETT: Perceptual.

DR. MYKLEBUST: Yes, that's right. Jim, do you want to come in here?

DR. CHALFANT: No. He said it.

DR. MYKLEBUST: All right. Then "handicap" refers to or means-- What do you want, Bob?

DR. RIDGWAY: The group we used yesterday -- sensory, motor, intellectual, emotional, or learning disability. I think you add it.

DR. DENO: Yes.

DR. HEWETT: Then what does "deficit" refer to?

DR. FLIEGLER: Let's play with that. We have to get something in here (indicating), Bob.

DR. MYKLEBUST: You do. Impairments?

DR. FLIEGLER: Impairments in sensory -- in the following areas, or something.

DR. HEWETT: Just put "impairments" at the end. Sensory, motor, intellectual impairments and learning disabilities.

DR. FLIEGLER: You put something in there?

DR. HEWETT: Put in "impairments" after "intellectual" and tag on learning disabilities.

DR. MYKLEBUST: Yes, you can. All right. Fine.

DR. FLIEGLER: Which of these two words? Handicap?

DR. KASS: Handicap.

DR. FLIEGLER: Make a choice for me. Do you want to leave it that way for a while?

DR. MYKLEBUST: Frank, you think it's "deficits," don't you?

DR. HEWETT: That seems to me the word that needs to now --

DR. MYKLEBUST: It does to me.

DR. HEWETT: I'd like to replace "deficits" with "handicap" again. "Multiple handicap" refers to combinations of handicaps or handicapping conditions. I think "deficits" just-- It's a funny word. It doesn't fit there. I think we ought to keep it in the family a little more.

DR. KASS: Yes.

DR. BLAIR: I agree.

DR. MYKLEBUST: Let's try it out this way. We're going back to the original now. "Multiple handicap" refers to combinations of handicaps, Lou. I think if we don't have to put in "handicapping conditions," we're a little better off.

Combinations of handicaps. Now you have to take off "in ways."

DR. BLAIR: No, which interact.

DR. MYKLEBUST: I'm sorry. It's over there. Excuse me. Which interact to impede development and learning. I'm sorry. All right? Agreed? That's fine.

Jim?

DR. CHALFANT: If we're going to do this, then could we say "combinations of handicaps" refers to two or more impairments in sensory and so forth?

DR. MYKLEBUST: Corrine, this gets to your point. Does that --

DR. CHALFANT: This comes back to Corrine's point.

DR. MYKLEBUST: We can do this in this way, Corrine, perhaps.

DR. KASS: Yes.

DR. MYKLEBUST: Go ahead, Jim.

DR. CHALFANT: We get in trouble with "impairments" again. "Combinations of handicaps" refers to --

DR. DENO: Why don't you say "multiple handicaps" refers to combinations of sensory --

DR. KASS: No, no. That's just repeating.

DR. CHALFANT: Then we have our definition again.

Refers to two or more. Now we have to make a modification.

DR. KASS: That's all right.

DR. CHALFANT: Wait a minute. No, we don't. That's good. Refers to two or more sensory, et cetera.

DR. HEWETT: Get rid of that second "refers to." Is there any way?

DR. ASHCROFT: Can you say "and/or learning disabilities"?

DR. WOLFE: It's not right the way it is there. It's not correct.

DR. SELZNICK: I wrote, "The 'multiple handicap' refers to those with two or more deficits in" -- and then the last part of the sentence.

DR. WOLFE: That wouldn't be right either.

DR. FLIEGLER: There was something you were trying to tell me. I got a little lost.

DR. MYKLEBUST: Go ahead.

DR. FLIEGLER: Jim?

DR. CHALFANT: "And/or learning disabilities" at the end.

DR. FLIEGLER: I see. Okay. And/or.

DR. CHALFANT: The only thing here is when you take out "deficit" you are defining the term with one of the words of the term. You are defining "handicap" with "handicap."

DR. WOLFE: Where?

DR. MYKLEBUST: Where is this?

DR. CHALFANT: You have "multiple handicaps" and then this refers to combinations of handicaps.

DR. HEWETT: That's exactly what it is.

DR. BLAIR: You're going on to explain it.

DR. CHALFANT: All right.

DR. KASS: You don't need that "and/or."

DR. MYKLEBUST: Corrine doesn't think you need "and/or."

DR. KASS: You are saying two or more.

DR. CHALFANT: Okay.

DR. WOLFE: Wait a minute. Wouldn't that mean then he would have to have one of the others and the learning disability?

MISS TAYLOR: Yes.

DR. KASS: Two or more of --

DR. HEWETT: He'd always have to have a learning disability.

DR. WOLFE: He'd always have to have a learning disability.

DR. KASS: Two or more sensory, motor, emotional, intellectual --

DR. MYKLEBUST: Intellectual type impairments or learning disabilities.

DR. KASS: Or. I guess "or."

DR. FLIEGLER: "Or"?

DR. WOLFE: Then that would say anyone with learning disability would have a multiple handicap.

DR. MYKLEBUST: When you put "or" in, does it? What does?

DR. WOLFE: The "or."

DR. MYKLEBUST: Then we can't use that. I think we are in trouble here with that.

DR. FLIEGLER: Remember this-- Oh, okay.

DR. RIDGWAY: Do we need an "or" between "emotional" and "intellectual"?

DR. MYKLEBUST: Sensory, motor, emotional, intellectual impairment or learning disabilities. Yes. Another "or" does not do it, does it? Now, "and/or" doesn't do it, does it?

DR. FLIEGLER: Could I try something? Two or more impairments in-- Would that help?

DR. DENO: Sensory, motor, emotional, intellectual, or learning disability areas.

DR. SELZNICK: Function.

DR. WOLFE: Learning disability isn't a function.

DR. FLIEGLER: Yes, but you have the "impairments" there which qualifies it. Is that getting what you are trying to say?

DR. DENO: Or "deficits" there.

DR. FLIEGLER: Two or more impairments.

DR. ASHCROFT: Change "disabilities" to "characteristics."

DR. FLIEGLER: Two or more impairments or deficits? And over here functions and characteristics?

DR. BLAIR: I don't think so, Lou. We have made "learning disabilities" a generic term now, and it has to be --

DR. FLIEGLER: That's right. That's what I was going to refer to.

DR. MYKLEBUST: You'd have to take out-- Oh, yes, "impairments" comes out over here.

DR. FLIEGLER: "Impairments" would come out.

DR. MYKLEBUST: "Or learning disabilities."

DR. FLIEGLER: There is an "area" here somewhere.

MISS TAYLOR: How would it be if we said "combination of handicaps" refers to two or more of the following -- learning disabilities, sensory, motor, intellectual, emotional or motor impairments?

DR. CHALFANT: She almost has it there, I think.

DR. MYKLEBUST: Yes, that's close.

DR. CHALFANT: Learning disabilities and sensory, motor, emotional, intellectual impairments.

MISS TAYLOR: Leave out the "and" because that makes it sound as though it has to be-- Just a comma.

DR. MYKLEBUST: Now, singular, Jo, not plural. Learning disability. Okay?

MISS TAYLOR: Yes.

DR. FLIEGLER: Two or more of the following. Right?

DR. MYKLEBUST: Yes. First learning disability.

MISS TAYLOR: Then a comma.

DR. MYKLEBUST: Learning disability -- comma.

Go ahead, Jo.

MISS TAYLOR: Sensory, motor, intellectual, emotional or motor-- Oh, I have "motor" twice. Sorry. What's the other one? Impairments.

DR. DENO: Emotional. Do you have that?

DR. MYKLEBUST: We have the following: Learning disability-- Now, let's take them again, please. Sensory, --

MISS TAYLOR: Where is our list up there?

DR. MYKLEBUST: Go ahead, Jo.

MISS TAYLOR: Sensory, motor, emotional, or intellectual impairments.

DR. HEWETT: Would "involve" replacing "refers to" make it smoother? Combinations of handicaps involve two or more of the following, so we don't get the double "refers to" from the first sentence.

DR. MYKLEBUST: Let's put in "involves" and take out the other. Involves two or more of the following: learning disability, sensory, motor, emotional, or intellectual impairment.

DR. HEWETT: Singular, isn't it? Combinations of handicaps involved?

DR. MYKLEBUST: You're right. That's correct.

Now, that has come a long ways. How is it going?

Yes, Bob?

DR. RIDGWAY: Do we need "learning disability," or is this an intellectual impairment? I know why we put it in there, but --

DR. MYKLEBUST: The "intellectual" refers to the retarded now. "Learning disability" is a separate category.

DR. BLAIR: It's generic now, we hope.

DR. MYKLEBUST: Otherwise we haven't done anything about learning disabilities.

MISS TAYLOR: Well, maybe we should say "retardation" instead of "intellectual impairment," and then we can avoid that.

DR. MYKLEBUST: Yes.

DR. DENO: Sensory, motor, emotional impairment or --

MISS TAYLOR: -- retardation.

DR. KASS: Why don't we use "emotional disturbance" too, as long as we are going to use terms which are most commonly used.

DR. RIDGWAY: Sensory or motor impairment, emotional disturbance, or mental retardation.

DR. KASS: Sensory or motor impairment, emotional disturbance, or mental retardation.

DR. SELZNICK: It's a long term. I think the definition is stronger with "intellectual impairment." I think eventually the light is going to be seen, and "mental retardation" will be less commonly used.

DR. BLAIR: But right now, Harrie, I think it communicates more directly what we are trying to say. We should try to use current terminology.

MISS TAYLOR: I was trying to get around that idea of learning disability being intellectual impairment.

DR. RIDGWAY: This is picky, but is there a particular order which we should use here?

DR. MYKLEBUST: Do you have any suggestion?

DR. HEWETT: Just that mental retardation might belong before emotional disturbance, that kind of thing. You might move from the physical through kind of physical to --

DR. KASS: We can put mental retardation right here after learning disability.

DR. HELLER: I don't know. Jo here has a point -- mental retardation and the intellectual impairment.

If you speak of a child who is a slow learner in conjunction with another handicap, he wouldn't fit.

MISS TAYLOR: Yes. And particularly thinking about when it is in combination, as Mike has pointed out, you might consider a person who had a little more than retardation still belonging in a special program of that type.

DR. ASHCROFT: Can you introduce a little more flexibility too so that cultural deprivation, for example, or-- I'm thinking of combinations of handicaps. You know. A "such as" clause so that you don't close the door.

DR. MYKLEBUST: But, you see, these are separate problems and are really-- I think we can't-- I don't like the term "jurisdiction," but I don't think we can in this area of special education get into what the cultural deprivation problem means or represents here, Sam, again on the basis of the fact it's manipulation of environment and opportunity rather than defect.

I think that we will not be able to justify any inclusion of this cultural deprivation aspect in this definition.

DR. HATLEN: You included something yesterday though that belongs in here someplace I think, and that is lack of opportunity to learn. Maybe it is covered in some other area, but --

DR. MYKLEBUST: Well, we included it yesterday, Phil, in the sense it was not our problem. We said "does not include those with lack of opportunity to learn." And that is still true today. And that's what I am saying.

DR. DENO: Also here we did before, at least, when we were talking about the parameters, say that this group of children is a group who need educational services beyond that which is typically provided. We changed the words, but the concept is there.

So that the lack of opportunity in this instance would have to be the lack of opportunity in the conventional special education program.

DR. MYKLEBUST: That's right.

DR. DENO: That is, the screening lack of opportunity.

DR. MYKLEBUST: Yes. Now, this then reads this way: "'Combinations of handicaps' involved two or more of the following: learning disability" -- and we will come back to this problem, Bill Heller -- mental retardation, sensory or motor impairment. or emotional disturbance." Right? We need one more "or."

DR. HEWETT: If you put emotional disturbance in the very beginning, that would take care of it.

DR. MYKLEBUST: That's right. It would. Learning disability, emotional disturbance, --

DR. KASS: All right. Or sensory or motor?

DR. MYKLEBUST: No, we're talking about "the following" -- up there by "the following." Put "emotional disturbance" in there.

DR. HEWETT: Then it goes from the social, emotional, --

DR. MYKLEBUST: Emotional disturbance, learning disability, mental retardation, sensory or motor impairment.

MISS TAYLOR: I'm back to not liking the "mental retardation."

DR. MYKLEBUST: I said we'll come back to it, and that's where we are right now. Now, there is some feeling here that the term "mental retardation" is not-- Thanks, Lou. Good luck. -- is not as useful or, that is, has connotations which some of our members would not like to include here.

Now, I'd like reaction of some of the rest of you in this connection. I wouldn't have thought of this, but I see your point. I think "mental retardation" is today used in a fairly restricted sense, and I think this is what Harrie, Bill Heller, maybe Jo are referring to.

So I would like you to consider what we might use that would not jeopardize the intent of the practical implication and so on.

But let's at least consider possibilities for "mental retardation" such as-- What did you say, Bill?

DR. HELLER: Well, the "intellectual impairment" is acceptable.

DR. MYKLEBUST: Well, then --

DR. HEWETT: You don't need "impairment" then.

DR. MYKLEBUST: You would have intellectual, sensory, or motor impairment. Is that all right, Frank?

DR. HEWETT: Yes.

DR. MYKLEBUST: Now, Harrie, how does that sound to you?

DR. SELZNICK: I prefer it, personally.

DR. MYKLEBUST: All right, Jo?

MISS TAYLOR: Yes, I think so.

DR. MYKLEBUST: Now, then, it reads like this -- and check me, Corrine: "'Combinations of handicaps'"-- "'Combinations of handicap'"-- That's singular, isn't it? "Handicap"? Or is it plural? No, you have it plural. "'Combinations of handicaps' involve two or more of the following: emotional disturbance, learning disability, intellectual, sensory, or motor impairment.

I like that. Okay? I think it's a good correction. Don't you like it, Phil?

DR. HATLEN: I'm just a little bit reluctant about the word "involve," and I wouldn't-- If this doesn't sound right to anyone, I'll be very quick to drop it. But what about "indicate a presence of"?

DR. DENO: I like that better myself.

DR. MYKLEBUST: I'm sorry?

DR. DENO: I like that better.

DR. MYKLEBUST: You like that better?

DR. HATLEN: I don't see how "involve" fits.

DR. MYKLEBUST: Combinations of handicaps-- Well, you don't want "indicate" though, do you?

DR. DENO: The term "indicates" you see --

DR. MYKLEBUST: "Indicates" is difficult in a definition. "Combinations of handicaps" means presence of?

DR. DENO: Yes, means the presence of.

DR. HATLEN: Yes.

DR. MYKLEBUST: These are all exploratory here to see if we all agree on this. The last one came out beautifully. This one may.

Now, Phil, is that what you mean?

DR. HATLEN: Yes.

DR. MYKLEBUST: All right. Frank Hewett, is it what you mean?

DR. HEWETT: "Means" is a funny word.

DR. WOLFE: Refers to the presence of.

DR. MYKLEBUST: Then we are back to "refers," which we were taking out.

DR. WOLFE: I know.

DR. MYKLEBUST: But I think "means" isn't a good word either.

DR. HEWETT: That's not really what we intend.

DR. MYKLEBUST: But you don't like "indicates," do you?

DR. HEWETT: No, that doesn't --

DR. MYKLEBUST: It's a very indefinite term here, and we don't mean just "indicating," Phil. We mean it is.

DR. HATLEN: Identifies?

DR. SELZNICK: Specifies?

DR. MYKLEBUST: That's the kind of term we mean.

Corrine, did you have a suggestion?

DR. KASS: No.

DR. MYKLEBUST: Combination of handicaps indicates-- Or what is better than that?

DR. WOLFE: Denotes.

DR. MYKLEBUST: Jo, you have a lot of words.

DR. WOLFE: Denotes.

DR. MYKLEBUST: How about "denotes"?

MISS TAYLOR: That's good.

DR. MYKLEBUST: "Denotes." I like that. Okay? Bob Ridgway, all right?

DR. HEWETT: We don't need the "presence of" then, do we?

DR. MYKLEBUST: No, you don't.

DR. BLAIR: I don't think you do.

DR. MYKLEBUST: You really don't, do you, Sam?

DR. ASHCROFT: Very good.

DR. MYKLEBUST: Two or more of the following. It leaves it a little vague without something. The "presence of" was something for me I find.

DR. DENO: Or the existence of.

DR. MYKLEBUST: Denotes the presence of, or denotes the existence of. It gets awkward though. Do we need it?

DR. BLAIR: I think it stands the way it is.

DR. MYKLEBUST: You're satisfied the way it is?

DR. BLAIR: I think it stands.

DR. MYKLEBUST: All right.

(Statement on the board now reads: "'Combinations of handicaps' denotes two or more of the following:. . .")

MISS TAYLOR: Can I throw in one more idea?

DR. MYKLEBUST: Sure. Go ahead.

MISS TAYLOR: At the end, could we say "or other debilitating conditions"?

DR. BLAIR: How about "other health impaired"?

(Laughter)

MISS TAYLOR: I'm thinking of this "other," because I really think that we do have a problem with children-- You know the "tied in the crib" thing and that type of thing which involves this lack of opportunity. Or there may be some others that we haven't thought of. So this would give us a little leeway.

DR. MYKLEBUST: My feeling is this is implied and would be troublesome to tie in. I think you would be constantly explaining what you mean by "other" -- other aspects, factors.

It seems to me, Jo, we would be asking for difficulty beyond what we would expect.

Yes, Phil?

DR. HATLEN: Maybe Frank can answer this for me. A blind child who spends his entire preschool experience in a playpen when he comes to school is emotionally disturbed?

DR. DENO: I'd say he had a learning disability, because yesterday we defined "learning disabilities" as being essential processes of perception, and so on. And it would be these things which he would lack.

DR. CHALFANT: Acuity.

DR. RIDGWAY: Is he a deprived child?

DR. HATLEN: Is he culturally deprived?

DR. HEWETT: He'd be emotionally disturbed, I'd say, but that is perhaps-- That is a moot point really.

MISS TAYLOR: Socially maladjusted too.

DR. SELZNICK: Environmentally different.

DR. DENO: Harrie and I wouldn't have any problem. We'd just serve him.

DR. SELZNICK: That's right.

DR. MYKLEBUST: He would, of course, be seriously deprived in experience, and so on, which would implicate perceptions, emotions, various things involved.

Go ahead, Phil, with your question.

DR. HATLEN: No, I'm just trying to be a little more specific about what I think Jo was saying. These are the kind of kids that we get in school whom we consider multiple handicap. And if we try to pin down the cause, maybe we're not hitting the definition.

DR. MYKLEBUST: Yes. Now it seems to me you have the freedom of interpretation of whether you want to classify this as multiple involvement or, rather, a variation from the basic norm group, which in this case would be the blind, and so on. You have to meet his need. So I don't think you can spell all this out in this.

MISS TAYLOR: No, and I think really what happens to that child is included in this whole long list of other impairments, you know, the motor, the --

DR. HEWETT: What about the delinquent kid, the social problem? You have the category "social or emotionally maladjusted? Is that what they sayin the Office?

DR. MYKLEBUST: Yes. They are not included here.

DR. HEWETT: No. Is a delinquent a kid who has got a learning disability plus he's a delinquent? Is he a multiply-handicapped kid?

DR. MYKLEBUST: Well, if you are asking me, I happened to spend much of my time for five years -- not full-time, but much of my time for five years -- as a chief psychologist in the juvenile court in a rather tough industrial area in the East. And I would have to say that I think he is very seriously multiply-involved as I would see him.

In the first place, the incidence of hearing loss is at least twice the average. The incidence of visual impairment is three to four times the average.

Incidentally, visual impairment is running much higher than any single factor in our survey in the public schools -- much higher than any other single factor.

Now, maybe our criteria-- Maybe we set the criteria too loose or something. But these youngsters tend over and over again-- And, of course, a psychiatrist just wrote a book on Lee Oswald which rather clearly in my opinion indicates he was a severe learning disability individual from early life. He wasn't able to read, write, spell, and so on, you see.

So there is a tremendous acting out on the part of a lot of these.

Recently I had to spend a long time in court -- I get subpenaed at the drop of a hat -- on this deaf mentally retarded Negro man who assaulted a woman and killed her. He had no lipreading, no speech, no sign language.

So, of course, I knew all about how to find out how much intelligence he had. (Laughter)

Believe me, these are tough problems, aren't they? I mean you are supposed to read his mind, you know.

But we did get him out of the electric chair.

Now, I'm saying there's lots of this involved in all of this, Frank, and it is an extremely important question socially. I think it is implied rather than spelled out in terms of our special education definitions today and yesterday.

DR. HEWETT: We didn't put "social" in yesterday either, did we?

DR. MYKLEBUST: No, we didn't. Evelyn?

DR. DENO: We left speech out. Is that deliberate?

DR. MYKLEBUST: Yes, it is deliberate on my part. I think of speech as a different entity here. But not language. We put language in, verbal or nonverbal, in learning disability yesterday.

DR. HEWETT: "Intellectual" covers speech here really.

DR. MYKLEBUST: That's a very good point we should consider for a minute. Under learning disability we have verbal and nonverbal according to yesterday, meaning language.

DR. DENO: Okay.

DR. MYKLEBUST: Now, an articulation defect I would deliberately leave out if I am --

DR. BLAIR: Yes.

DR. DENO: I forgot it was in learning disability.

DR. MYKLEBUST: I would say that speech per se, articulation, is not included at this time.

DR. WOLFE: How about stuttering?

DR. MYKLEBUST: Definitely not. And not cleft palate speech. Cerebral palsy would be included under motor, and so on. But if they have only articulation, they wouldn't be included. They'd be included under the motor, you see.

DR. WOLFE: Where would you include stuttering?

DR. MYKLEBUST: Well, stuttering as a category is a difficult one, Bill, and I know nothing about speech, stuttering, and so on. It's not my field, despite the fact I'm in the School of Speech and in a department where this work is done. I personally am not certified in any of it, and I have not been trained. I was a psychologist, as you know.

So I feel that stuttering is not the kind of handicapping condition that special education has been concerned with and as such is not included.

DR. DENO: We provide it under special education programs though, and what we said up there was "multiple handicap" refers to combinations of handicaps which interact in ways which require special education services different from those required for children with a single handicap. So there are many instances in which we do have to draw in speech service in combination with services for the orthopedically handicapped or whatever.

DR. MYKLEBUST: And that is intended, isn't it?

DR. DENO: Yes.

DR. MYKLEBUST: And including those in all of these categories that stutter, Bill, they would be in, like retarded stutterers, emotionally disturbed stutterers. Of course they would be in.

DR. CHALFANT: There is a point that seems to be coming up here, and I'm not sure we have touched on it or not. That is, there may be a child with a multiple handicap, and it may be that you would treat this as two-- In terms of treatmen it would be treated as two distinct handicaps as opposed to a child that has a multiple handicap, as Sam has indicated, where it would be something quite different.

In other words, you might have two handicaps where you wouldn't get the interaction that we are talking about here.

DR. MYKLEBUST: Like an articulation problem?

DR. CHALFANT: Like an articulation problem and a reading problem. You wouldn't get the interaction. A little bit, you know. If it affected the phonics, perhaps slightly.

DR. MYKLEBUST: Reading dyslexia. Now, reading disability as a total area, no. But dyslexia is in learning disability. So are all the aphasias. So are the spelling disorder They are all in under learning disabilities.

DR. KASS: May I suggest something else? Since we are trying so hard to think of all the possibilities here, instead of being so concise on the handicaps, why don't we name everything that we can think of, deaf, blind, partially hearing, partially sighted?

DR. MYKLEBUST: It's extremely difficult, you know. You notice I sent something out to you in that connection in which I was just exploring. Actually, I have looked at it, and it has many loopholes in it and is not very useful. You can tabulate sort of thing. I wouldn't do it the way I sent it out to you again, because there are too many problems with it. I think you run into all kinds of difficulties.

I think more generic terms have much more usefulness. Most definitions try to spell out too much and become entirely useless in a short time.

MISS TAYLOR: Too limiting.

DR. MYKLEBUST: Too limiting.

DR. SELZNICK: I agree.

DR. MYKLEBUST: Now, it is about time to break for lunch. Any comment from you, Sam, on this this morning?

DR. ASHCROFT: No.

DR. MYKLEBUST: Corrine, anything else?

DR. KASS: No.

DR. MYKLEBUST: Anything else?

DR. HEWETT: Are we going to need to clarify "special educational services" in addition?

DR. MYKLEBUST: Well, I thought, frankly, that we would have to come back to this after lunch and see where to go from here.

DR. HEWETT: Interaction or whatever?

DR. MYKLEBUST: There will be other considerations necessary here.

DR. WOLFE: Would it totally be out of the question to consider adding the word "speech" after "sensory" and before "or"?

"Intellectual, sensory, speech, or motor impairment"?

DR. BLAIR: I agree with Mike. I don't think that speech belongs here, despite the identification of this in the funding program. I think this is not, strictly speaking, special education.

DR. MYKLEBUST: All right, Bill.

DR. HELLER: I might just mention in the Office they are thinking of organizing branches now, and sensory will include speech. In other words, sensory disorders will include vision, speech, deaf.

DR. BLAIR: But, you see, speech and language are in conflict here, and I think we are talking about language.

DR. HEWETT: That comes under "intellectual" really.

DR. BLAIR: No. Learning disability.

DR. HEWETT: That's right. But it could also come under that.

DR. MYKLEBUST: Any other preference? Corrine, do you have any other statement of preference?

DR. KASS: No.

DR. MYKLEBUST: I think the preference of the group would be to not get involved in the rather long, arduous difficulties you can get into by putting the term "speech" in. And I say this because speech itself-- Now, we might disagree with this, and we could put it in. If we disagree with this and want to, I think we should. But I think you all know that speech deliberately does not include itself under special education.

Now, there is a little movement under CEC at this time. I don't mean CEC is agreeing, but they are trying to do it through CEC -- to do the same with learning disability -- keep it out. "We don't want to be in education. We don't want to be in special education." See?

Now, speech as a group obviously does not declare themselves as part of education or special education. Now, how are you going to handle this in terms of your classifications? I don't know, Bill.

DR. WOLFE: But in the State program, as you pointed out, we have it. We have this as a special educational service.

DR. MYKLEBUST: That's true. That's right. I agree. That's right. That's where it falls.

DR. ASHCROFT: We are naming characteristics of children too, not programs.

DR. MYKLEBUST: Yes. You're quite right. That's right. It is not included now by the way we have defined the other categories. It was not included under learning disability.

DR. ASHCROFT: That was my point earlier in loosening this up. These are just illustrative, and someone will always think of some combination that isn't covered. And if we had a clause that would allow whomever wanted to be included to be --

DR. SELZNICK: Am I introducing a problem? We do have sensory, et cetera, in there. Could we talk about "communication problems," which would be more inclusive, thinking of the language?

DR. MYKLEBUST: As I said yesterday, the term is almost useless in most scientific discussions today, and I think education, because it simply doesn't mean anything. Do you mean what Joe Lilley means in the Porpoise? You immediately get into that. Do you mean what you talk about today in the language of all forms of life? Do you know what the communication theorist means? He doesn't even refer to language. The recent book, "Language Theory," hasn't even mentioned symbol. They are interested in-- Their term is "signals." This is strictly at the programming signal level.

So communication in a school in which we get into a lot of this has almost been thrown out.

I think many people would say that communication today has to be defined in many ways or you aren't saying anything. There is nonverbal communication. Look at the great work of Hall, Edward T. Hall. He just joined our staff in Anthropology. This is a fabulous work called "The Silent Language," which isn't anything of what we are talking about. And it's communication.

Jim?

DR. CHALFANT: Now, it has come up several times. I can differentiate fairly well between learning disability and mental retardation, but when I look at intellectual impairment and learning disability I have trouble. I see overlap.

DR. MYKLEBUST: But there isn't in the definition yesterday. We said they had normal intelligence. That is strictly spelled out.

DR. CHALFANT: That's it. When I look at "intellectual impairment," I'm thinking of something other than mental retardation.

DR. MYKLEBUST: I see what you mean.

DR. CHALFANT: As Frank said, language is an intellectual impairment.

DR. MYKLEBUST: That was with us yesterday and this morning. That's right. So "intellectual impairment" is very broad and doesn't necessarily mean mental retardation. No, I think you're right.

DR. BLAIR: But it could.

DR. HATLEN: What Sam suggested is put the word "may" before "denote."

DR. MYKLEBUST: Then we are back in the vague thing.

DR. HATLEN: Wide open.

DR. MYKLEBUST: You have nothing now.

Now, we have a little difficulty. Do you want to talk about it over lunch? We have a little difficulty with some of these. Do you want to be back at one o'clock to get through earlier?

(DISCUSSION OFF THE RECORD.)

DR. MYKLEBUST: I must tell you we started at eight o'clock in order to speed up. The schedule was to go until five. Obviously that brings us up to four o'clock. Now, is there anyone who has to leave before four?

DR. HEWETT: It would help me if I could catch the 3:45 limousine.

(Discussion off the record concerning arrangements.)

DR. MYKLEBUST: If we terminate at three o'clock, you could make it. I'm inclined to think we will accomplish everything we can with this within two hours -- that is, from one to three this afternoon -- and then we will terminate.

All right. Is that agreed?

All right.

(Whereupon, at 12:05 p.m., the luncheon recess was taken.)

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AFTERNOON SESSION

1:15 p.m.

DR. MYKLEBUST: Our procedure in the little time that remains will, as much as we can, be as follows: We need a few minutes -- and I would really like to limit it to a few minutes because we do have another consideration that needs discussion before we terminate today -- but we need to clean up a little the term "intellectual," because I think three or four of you have raised questions about its suitability for the purpose here.

Now, the alternative was "mental retardation." Harrie felt it limiting. Bill Heller felt it limiting. Some of you feel that "intellectual" is a term which now doesn't really cover what we mean here.

And if I should take a position, I can see your point, and I suppose it does not mean really -- except as we read into it -- what was intended here.

The intention I believe was that this would be the problem of mental retardation along with other aspects.

So I must call your attention again to this fact -- that "intellectual impairment" is being questioned as not meaning mental retardation, not even including it or implying it to some of you.

Now, is there -- may I qualify -- serious objection to putting "mental retardation" back in? "Emotional disturbanc learning disability, mental retardation, sensory or motor impairment"?

DR. BLAIR: I guess the area that concerned these gentlemen was, of course, the area that doesn't fall within limits and doesn't fall within the retarded area. This would be the gray area between the educable and the normal. And I think, Bill, you were speaking to --

DR. MYKLEBUST: Now we get into the problem of defining mental retardation. In the little writeup I sent you I did specify that they would fall from 90 IQ and down, including this slow learning. So slow learning here would be included under mental retardation as intended.

MISS TAYLOR: However, that is not what most persons think of under that.

DR. MYKLEBUST: Jo, I'm afraid that's right. I suppose most people today I would guess would mean trainable. Certainly a lot of them do.

We have limitations on each term here. I don't think there is an ideal solution for us. I think perhaps we have to take the one we think does best for the purpose.

Yes, Bob?

DR. RIDGWAY: In terms of the intent of Congress, and so on, in setting up these laws, if we had a youngster who let's say was deaf and was a marginal case of mental retardation, theoretically this is a person who would not be eligible for care in a mental retardation program. But I think if we used the term "mentally retarded" here qualified as you used it, it wouldn't bother anybody, because we are saying that combinations of handicaps and their interactions are the things that give us problems.

DR. MYKLEBUST: Right. Yes. And the next concern now, if I could just structure a bit, because our next question will be interaction-- There is some need to look at these in terms of "different from services," "different from," because of interaction. And we will come to that as soon as we clean up this terminology a little bit more.

I do remind you I don't think we are going to be able to get terminology here that is ideal or that suits all purposes. We are going to have to use what we think is best and then leave it there.

I don't want to, you know, ask each of us for a commitment here. But let's ask again: Is there any serious objection to "mental retardation" there after "learning disability"? Is there anyone who is very unhappy with that?

DR. SELZNICK: I think you have to define the purposes for arriving at a definition. If it's for immediate purposes, for present purposes, I think "mental retardation" is all right.

DR. MYKLEBUST: I see.

DR. SELZNICK: If you're thinking of trends and directions which you think the field should take, well, then, I would be uncomfortable with it.

So I think purposes determine, actually.

DR. MYKLEBUST: Well, I will try to interpret and infer from our discussions, Harrie. I think what we have been doing has been staying with the basic categories and classifications rather than trying to establish new ones. And it is then likely that in the future this would have to be modified as the trend comes along perhaps in other ways too, Harrie.

It seems to me our purpose now is fairly immediate -- in other words, using that which is most generally used -- and "used" is very redundant here -- but is most generally followed at this time. Is that what we have been doing?

DR. WOLFE: Yet, Mike, when you say the specific category of mental retardation, you are not doing that for othe specific categories like the deaf and the blind and the cerebra palsied and all this.

As it is now, that term is somewhat comparable to the others. It is an intellectual deficit, a sensory deficit, a motor deficit.

DR. MYKLEBUST: Well, actually you're right. We are mixing terms. Learning disability is only that area, you see.

DR. WOLFE: That's right.

DR. MYKLEBUST: Now, in sensory we are including all of the sensory, auditory and visual.

DR. WOLFE: I know.

DR. MYKLEBUST: Instead of because we have a term. In motor we are including all of those.

DR. WOLFE: I know.

DR. MYKLEBUST: So we have some specific and generic terms here.

DR. HELLER: Well, I think the most commonly accepted definition utilized is Heber's where he says mental retardation refers to sub-average general intellectual functioning.

Now, if we use "mental retardation," and with the implications you made that you are talking about a child with below average, average being 90, then I would accept it. Actually, using "mental retardation" doesn't bother me that much, because it gives me the identity and the vision, whatever I want here, from my angle.

But I am concerned then about the child who is 85 who certainly is a slow learner in the State of Illinois, for example, who would not be multiply-handicapped under this definition, who has also, let's say, a deficit in hearing. What happens to him then?

DR. MYKLEBUST: You mean because we are using the term "mental retardation" he wouldn't be included?

DR. HELLER: Here in the State of Illinois he wouldn't. We are saying that he has to have two or more.

DR. MYKLEBUST: No, he wouldn't be a multiply-handicapped unless he has more than an 85 level of intelligence problem, no. That's right. But neither would anyone else.

DR. HELLER: No, I'm saying he isn't really mentally retarded.

DR. MYKLEBUST: So you are saying the term "mental retardation" wouldn't include this chap in Illinois?

DR. HELLER: That's right.

DR. MYKLEBUST: This is the problem, of course.

DR. HELLER: Even though the combination-- He certainly needs a different type of program, you see.

DR. MYKLEBUST: This is the problem.

DR. ASHCROFT: Couldn't he get it through the hearing handicap program, program for the hearing handicapped?

DR. HELLER: Well, they haven't settled on that issue here in this particular State. In most States I think this is true too, as far as hearing, partially hearing, or whatever. I don't think he would get it in the deaf programs here in the State of Illinois or most States.

DR. MYKLEBUST: He'd be picked up through it if he has deafness or visual impairment and would be classified, yes.

DR. HELLER: But the complementary treatment here, the concomitant action we are talking about with other services, would not likely be made available.

DR. MYKLEBUST: Well, I can't comment on that. It probably wouldn't be made available in lots of States. We are trying to show how it should be.

DR. HELLER: But the semantic problem here doesn't bother me. We go by "mental retardation" in the Office.

DR. MYKLEBUST: All right. Very good. Do you then prefer the term "mental retardation"?

DR. DENO: I don't "prefer" it.

DR. MYKLEBUST: What?

DR. DENO: I don't "prefer" it. You know. It just falls within the purview of what we are doing.

DR. MYKLEBUST: All right. Is it better? Jim, you have problems with the other one.

DR. CHALFANT: Yes. I have fewer problems with "mental retardation" than I do with the "intellectual" term.

DR. MYKLEBUST: All right. Frank Hewett? All right?

DR. HEWETT: I would agree, yes.

DR. MYKLEBUST: If we are satisfied then, despite the limitations of the term, this will then read: "'Combinations of handicaps' denotes two or more of the following: emotional disturbance, learning disability, mental retardation, sensory or motor impairment."

Now, then, if this is agreeable, I should like to move on to the next part of the elaboration or clarification that we need here.

Now, I'm going by what I think some of you have been saying. And Corrine and I have been asking each other: Isn't there a need to say something similar to clarify-- I'm trying to get at what we now don't have. That is, that is this business of "it's not additive," to try to spell out what "different" means. It's not just adding them up.

We used the term "unique." We used the term "additive." It's not additive. And I thought a sentence or two about what we mean as special education services that are different because of the interaction and the type of imposition on development and learning that ensues-- What do you think? Could we take that for a bit?

I think the more creative aspect of this multiple handicap definition is this: Let's say that it seems to me in a way most of us, including ourselves, look at this in terms of deaf and retarded, deaf and blind, not something which develops as a different type of learning disability but different psychology of learning, imposition on learning. Can we say something here that would help educators recognize that we should no longer view this either in training of personnel or very precisely in terms of proper programming for the child to just talk in terms or think in terms of adding one, two, and three?

Now, we get to core curricula, courses which then are designed to cover the ways in which psychology of learning is modified by the interacting processes, interacting impositions.

Bob?

DR. RIDGWAY: I was thinking that maybe we had three terms left that we need to work on. One of them is the interaction business. Another is "special education service." And another one might be this one that you have just mentioned.

In the interest of getting things moving rapidly --

DR. MYKLEBUST: Go ahead.

DR. RIDGWAY: -- I was wondering if we could split up into about three groups and each group take one of those and spend five minutes trying to get a statement down that we could then work on, and then all come back together, and we would have a running start on those three statements.

DR. MYKLEBUST: I think this is very good. Would you on this side (indicating Miss Taylor, Dr. Selznick and Dr. Ashcroft) take "interaction"? Is that all right?

DR. RIDGWAY: Corrine should be in that group.

DR. MYKLEBUST: Corrine, you take "interaction" with these three people.

We have four there (indicating Drs. Chalfant, Ridgway, Heller, and Wolfe). Will you take "special education services"?

What is the third one, Bob?

DR. RIDGWAY: The one you just mentioned.

MISS TAYLOR: "Different."

DR. RIDGWAY: "Different from." That it's not additive.

DR. MYKLEBUST: That's right. Take "special education services" back there, please.

Will you take the uniqueness, different from any single or added one or two deficits (indicating Drs. Hatlen, Blair, Deno, and Hewett)?

(The Conference divided itself into subcommittees.)

DR. MYKLEBUST: Now, I think the sequence is to start here, as I recall. You are the ones involved with "interaction," aren't you?

DR. KASS: All right.

DR. MYKLEBUST: First we have the term "interaction." All right.

DR. KASS: "Interaction" refers to the correlation of deficits which results in behavior not characteristic of children with single handicaps.

Correlation of deficits which result in behavior not characteristic of children with single handicaps.

DR. HEWETT: "Correlation" just doesn't compute. It's the only word there.

DR. KASS: Shall I read the other one?

DR. MYKLEBUST: Yes, let's have all of them.

DR. KASS: "Interaction" involves the process by which the combination of handicaps produces an aggregate of adaptive characteristics which may not be present in each single handicap.

DR. MYKLEBUST: Any more, Corrine?

DR. KASS: No, that's it.

DR. WOLFE: We'll have to define the words now that you used and have sentences which define the words that were used.

DR. KASS: We could say "produces the adaptive characteristics." Never mind the "correlation."

DR. WOLFE: What do you mean by "adaptive characteristics"?

DR. KASS: Well, an example would be in the case of a deaf blind person who would not be able to use the other sense organ in compensation or as --

DR. WOLFE: Are you going to be there to read it to the person who should know it?

DR. KASS: No.

MISS TAYLOR: I wonder why we need to have the definition of the word "interaction"?

DR. MYKLEBUST: Now, this is a possibility I think. May I suggest, just to see where we are standing here-- Maybe we can combine again. We have heard this committee's suggestion I'd like to hear the others. It would help us I believe to take the whole.

Could we have the one down here which deals with special education services? Who has it?

DR. RIDGWAY: "Special education services" include provisions for identification and evaluation, placement, instruction, and rehabilitation of children who cannot profit from the program offered in the typical school situation.

DR. MYKLEBUST: All right. Once more.

DR. RIDGWAY: "Special education services" include provisions for identification and evaluation, placement, instruction, and rehabilitation of children who cannot profit from the program offered in a typical school situation.

DR. DENO: From the special education program offered in the typical school situation.

DR. MYKLEBUST: Go ahead, Bob.

DR.RIDGWAY: In this instance, "special education services" has to refer to general special education services, and then you are going to talk about why these aren't enough.

DR. DENO: Oh.

DR. RIDGWAY: For these kids.

DR. HEWETT: Is "rehabilitation" correct?

DR. WOLFE: It's "habilitation."

DR. HEWETT: It's "habilitation" much of the time, isn't it?

DR. MYKLEBUST: You get into a lot of trouble with that. Some of your more pure purists will point out to you, and quite rightly, that you can't find "habilitative" in the dictionary. But it is used a great deal. But really, according to I believe most excellent dictionaries -- we have been through this many times -- I believe you will find there is no such word. It is still used particularly I find in the field of speech correction.

As a matter of fact, we have on the books I believe in our bulletin a title of a course which uses the term. Don't ask me to report the hassle the faculty went through. Because apparently there is no such word at all. The man who was really defending this is an excellent dean in the sense of words and language, and it was extremely difficult for him to take. And I really couldn't blame him.

Now,any other suggestions down here? You have said what you have? You have given us your suggestion?

DR. RIDGWAY: We were not certain how to work "medical processes" into this, and before anybody jumps on us, the example that was used was an epileptic youngster who might be on drugs.

DR. MYKLEBUST: Yes, but these wouldn't be special education services, would they?

DR. HEWETT: Ancillary.

DR. MYKLEBUST: They are ancillary. I think we are holding to special education services here.

Now, then, the "different" idea here, the unique part of it. Who has that?

DR. BLAIR: All we did was identify three items. We did not combine them into a statement. But we were talking in terms of variations in traditional program organization for these children, innovations in methodologies -- in other words, qualitative differences from what we now have.

This is a little awkwardly stated, but teachers whose training reflects concern for the combinatory influence of the handicaps involved.

DR. MYKLEBUST: What kind of influence?

DR. BLAIR: Combinatory.

DR. MYKLEBUST: I'll have to get my dictionary.

(Laughter)

DR. BLAIR: It's in the dictionary.

DR. WOLFE: It is?

DR. BLAIR: Oh, yes.

DR. HELLER: Maybe we'd be better off if we stayed with our definition.

DR. WOLFE: I never heard that word. I'm sorry.

DR. MYKLEBUST: I never have either.

DR. SELZNICK: What does it mean?

DR. BLAIR: We can say "combinations."

DR. MYKLEBUST: Combinations of.

DR. BLAIR: "Combined" I'm sure would be --

MISS TAYLOR: Would you spell that word?

DR. BLAIR: Let's drop it. (Laughter)

DR. MYKLEBUST: I think we have Frank back against the wall. He has withdrawn. He doesn't have his dictionary in his pocket. (Laughter)

Jo raised an excellent question here a while ago. I had no idea. And I should have anticipated it. Because it's very obvious that we should have had a set of dictionaries around here.

DR. WOLFE: A thesaurus.

DR. MYKLEBUST: I didn't really think of it.

Now, we have the suggestions before us.

DR. WOLFE: Is he through? I'm sure there is more after "combinatory." (Laughter)

DR. MYKLEBUST: Are you through, Frank?

DR. BLAIR: I think so. I feel as though I am. (Laughter)

DR. WOLFE: You had three I thought. That was only one. I think we have a minority report.

Phil, go ahead.

DR. HATLEN: I tried in an awkward way to put some of this together, and I got "different from those required" refers to the need of multiple handicapped children for unique services not traditionally offered for singly-handicapped children. In some cases a combination of several services, each specific to a single handicap, may meet the educational needs of multiple handicapped children. In other cases new and innovative educational planning is required.

And I wouldn't want to spell out "new and innovative educational planning" anymore, because I don't think we know.

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And I wouldn't want to spell out "new and innovative educational planning" anymore, because I don't think we know.

DR. BLAIR: "New and innovative" is redundant. I'm going to pick on you. (Laughter)

DR. HATLEN: Okay.

MISS TAYLOR: Besides, if you put it down it won't be new.

DR. MYKLEBUST: I would like to take Jo's question now for all of us. It seems to me maybe I was imposing a bit here when I suggested that we needed to do this. Jo raises the question-- Let's take their area first. We really must take all of them, but we'll take theirs first. Do we need to spell out "interaction"? Is it clear enough? Is it better without spelling it out?

DR. HEWETT: There is no way really to define it without getting awfully abstract and kind of loose I think here.

DR. MYKLEBUST: I think you're right. And I think if there is any rule of thumb which could be applied it is that sometimes spelling out is really where you bring in trouble.

It's much more useful to more people sometimes if we don't spell out too much.

DR. SELZNICK: Yes.

DR. MYKLEBUST: Now, I want to sort of get some representative opinion. Corrine, how do you feel about it now? Do you feel that "interaction"could be left?

DR. KASS: Yes, I would very much like that.

DR. MYKLEBUST: I think giving thought to it and seei what it does is one way to decide not to do it, you see.

I think the point, the question, is very well taken that we might not spell out "interaction" but leave it for the manifest meaning that it has.

Evelyn, comments?

DR. DENO: No. That's all right.

DR. MYKLEBUST: Frank?

DR. BLAIR: It sounds good.

DR. HEWETT: Yes.

DR. MYKLEBUST: Nice work, Committee. (Laughter)

DR. SELZNICK: We "interacted" in order to come to that conclusion.

DR. HEWETT: Twice more and we'll be home free. (Laughter)

DR. MYKLEBUST: We'll apply this question to the others after this. After this consideration, what do you think about "special education services"? Do you want to spell it out?

Jim?

DR. CHALFANT: Well, something that happened here-- We all sat down and started writing things down in the way of services and came up with basically the same list. There were a few differences.

DR. MYKLEBUST: Well, there is validity in this process, you know, Jim.

DR. CHALFANT: And I think that's probably more concrete than "interaction," so I wouldn't be upset with not defining "special education services," although I like what we have.

DR. MYKLEBUST: Could we hear it again now, please?

DR. RIDGWAY: "Special education services" include provisions for identification and evaluation, placement, instruction, and rehabilitation of children, and so on.

DR. MYKLEBUST: Now, let's assume that is just up here now as further clarification of the definition. How do you feel about it? Does it add to it?

DR. DENO: I don't think it adds anything that anybody couldn't have defined, anybody in special education services.

DR. RIDGWAY: I think the only reason the matter came up at all was that there was question whether "services" was the proper word. And when we decided that "services" was more inclusive and included all these other things, then maybe we don't need it.

DR. MYKLEBUST: It is the result probably of a compulsive chairman who is trying to see we get these words out, so I am imposing some of this I am afraid.

DR. SELZNICK: Just to raise a question, I think we have to look at who is going to use this upon completion. Now, people with orientation in special education all came to the basic conclusion. If legislators are going to look at it, do they need a spelling out?

DR. WOLFE: They have spelled it out in their legislation.

DR. MYKLEBUST: Yes, but let's take the question now this way too, Bill. Because I think we agree there is a tremendous need in organizations like ACLD and many others to know precisely what we mean. And I have a feeling that it could be something that we are missing if we don't sort of tell them a little more about what we mean here in connection with this definition.

Go ahead, Frank.

DR. HEWETT: Can't we combine these two then? I think that is the logical thing to do.

DR. MYKLEBUST: Let's see how that goes then. Fine. Let's see how it goes.

Now, what is your list here, Committee 3?

DR. BLAIR: We have "combinatory." (Laughter)

DR. MYKLEBUST: You're going to combine the combinatories? (Laughter)

DR. BLAIR: Obviously we think ours is the most important of the three. (Laughter)

Variations in traditional program organization.

DR. DENO: Put them together with services in different ways than we conventionally do it.

DR. MYKLEBUST: I think that's important here. I thi this is really the creative aspect of the implications, isn't it?

DR. BLAIR: Yes, I think so.

DR. HEWETT: Variations and innovations related to --

DR. BLAIR: It seems to me the combinations of handicaps, the combinatory influence, must have innovative methodologies. It seems to me this is --

DR. DENO: There is a second one though.

DR. BLAIR: Yes.

DR. DENO: That is the one he is talking about where the combination of handicaps produces results for which you must apply different technology, not pulling together the ones that already exist somewhere in the roster that you have got in your cafeteria or whatever.

DR. MYKLEBUST: Bill?

DR. WOLFE: Try this: These services represent individual and unique programming and are not the sum of approaches commonly used with separate or individual problems.

Isn't that what we're talking about?

DR. MYKLEBUST: I think that's what we are talking about -- separate or individual handicaps.

DR. WOLFE: Or handicaps.

MISS TAYLOR: Read the whole thing.

DR. BLAIR: I just now repeated only two of them. The third one is what I am concerned about, and that is that our professional preparation must take into account-- If we are going to train teachers of the multiply-handicapped, we have to take into account --

DR. MYKLEBUST: But, Frank, I think this is a sentence that could, if you want to draw this implication for people-- It's a sentence you can add. You can add the sentence that this has implications for training, you see.

DR. BLAIR: Yes.

DR. MYKLEBUST: And it might be that we want to add such a sentence to get the implication right now.

Evelyn?

DR. DENO: You could state this almost so that it is parallel, and then the implication for training is there. That is, one was that you needed to combine the kind of services which you already offer in ways which are unique to this, which are created uniquely by this combination of handicaps. And the second is that for some kind of cases there may be innovations in methodology which have to be made because the combination produces a qualitatively different consequence.

And then the third one is that the people working with these children must understand the effects of the combination of handicap so that they apply the principle properly.

DR. MYKLEBUST: I think just such discussion -- which, fortunately, will be available to us in the transcript all the way through -- will be exceedingly helpful after this, even though we want to try to get as much of it said in this form today as possible.

But these discussions like this I think will be very useful to us on a long-time basis because it will be available.

I think then that we're all saying that we feel this is an exceedingly important aspect of the area of multiple involvement. If I may, I should like to ask Bill Wolfe to read his again for your consideration.

DR. WOLFE: These services represent specific and unique programming and are not the sum of approaches commonly used with separate or individual handicaps.

DR. MYKLEBUST: All right. Now, does that incorporate what you had over here?

DR. BLAIR: It is not explicit I think in terms of innovative methodologies, is it? Did I miss that?

DR. WOLFE: I said we could use innovative methodologies. I said "specific and unique programming."

DR. MYKLEBUST: Specific and -- ?

DR. WOLFE: And unique programming.

DR. BLAIR: The word "programming" gave us trouble before.

DR. MYKLEBUST: Specific and unique methodologies.

DR. WOLFE: Fine.

DR. MYKLEBUST: Is it better?

DR. HEWETT: You would precede that with your listing of the characteristics of services. Was that the-- You would exclude your listing of the categories of service?

DR. MYKLEBUST: I was assuming they would be excluded. We felt they were redundant.

Bob?

DR. RIDGWAY: There are two meanings to me at least for the word "programming" -- one, the red flag one that has been bothering people, and the other the more inclusive term that encompasses all the things that you do for a youngster from the time --

DR. MYKLEBUST: But it is a hard term to handle. I think we have been through that.

DR. WOLFE: We are going to use "methodologies."

DR. RIDGWAY: Maybe "methodology" doesn't get at all the things that are involved in the second definition of "program."

DR. WOLFE: Approaches.

DR. BLAIR: Bill, could you put that on the board so we could see that?

DR. WOLFE: Harrie, do you want to do that? I can't write. (Laughter)

DR. MYKLEBUST: Bill Heller, can you write? I see we have to get out our written language tests and see who qualifies. (Laughter)

DR. WOLFE: I can't write on the board.

DR. MYKLEBUST: Evelyn?

DR. DENO: Bill, when you say "programming" or "methodology," does that include people to you? Because I think it is important that the teachers, the psychologists, the people working --

DR. WOLFE: The programming would. The methodologies would not.

DR. DENO: I think it is important that the people managing the learning experience of these children understand the effect of this.

DR. WOLFE: I think that's a good point.

DR. DENO: And that should be in there.

DR. WOLFE: "Programming" would I think include people. "Methodologies" would not, as I see it.

DR. MYKLEBUST: I doubt it.

DR. HEWETT: "Planning" wouldn't do it.

DR. MYKLEBUST: I was wondering. Would "planning" do it?

DR. RIDGWAY: How about "programs and methodologies"? Use two words.

DR. MYKLEBUST: Yes.

MISS TAYLOR: I believe that our definition this morning was so clear and so succinct that anything we are adding this afternoon is making it more confusing and limiting rather than giving opportunity for expansion by innovative people.

DR. MYKLEBUST: Jo, are you including in that this "combination of handicaps denotes" part of it? You would leave that, wouldn't you? Just this afternoon's discussion?

MISS TAYLOR: I believe that that combination is good. What we did this morning I think is adequate.

DR. MYKLEBUST: Yes, I thought that's what you meant. Just this afternoon's then.

This question we will raise again as soon as we see this up here.

DR. HELLER: Is that plural or singular on the end, Bill?

DR. WOLFE: Singular.

DR. MYKLEBUST: It was meant to have two words I think. "These services represent specific and unique programs and methodologies." Am I right? Is that what we said?

DR. WOLFE: What Bob said, yes.

DR. MYKLEBUST: Programs and methodologies. Now I think we have it. Unique programs and methodologies. And are not the sum of approaches commonly used with separate or individual handicaps.

DR. HEWETT: "Include" is better than "represent" isn't it?

DR. BLAIR: I think it would be.

DR. MYKLEBUST: Include.

DR. SELZNICK: Yes.

DR. MYKLEBUST: All right. Change "represent" to "include."

MISS TAYLOR: I hope that they won't misunderstand and think that by "unique programs" -- that they will not feel it has to be a separate place.

DR. BLAIR: Yes. We had the word "innovative" in here, which I still like very much, and I wonder if perhaps that shouldn't be substituted.

DR. MYKLEBUST: Instead of "unique"?

DR. BLAIR: Instead of "unique."

DR. HEWETT: Doesn't "innovative" kind of denote --

DR. WOLFE: Experimental.

DR. HEWETT: -- an experimental kind of thing? You know. Somebody might say, "Well, I could come up with a unique program. I don't know whether I could come up with an innovative program." The criterion of more creative --

DR. BLAIR: Aren't we really trying to lead the way here a bit? I think we are suggesting we need a new approach.

DR. MYKLEBUST: We are trying to lead the way.

I would like to raise the question this way: "These services include specific programs and methodologies which are not"-- Leave out this (indicating) and not put a qualifier in there at all. ". . . include specific programs and methodologies which are not the sum of approaches commonly used."

You see, you are saying it down below. They are not additive. They are not the sum of, and so on.

If this word is troublesome up here, if "innovative" and "unique", and so on, are troublesome, you have a good statement without either word there, don't you, Harry?

DR. SELZNICK: I don't like the word "innovative" personally under any circumstances.

DR. MYKLEBUST: Well, "unique" is a little difficult too, I suppose.

Corrine?

DR. KASS: I feel this statement is merely restating "special education services different from," which is quite a clear statement.

DR. HEWETT: We are merely saying --

DR. KASS: We are saying here "unique and innovative" now instead of "different from."

DR. MYKLEBUST: We are trying to say why they are different. That's right. All right. Then, if --

DR. RIDGWAY: Do you need "specific" in there?

DR. MYKLEBUST: I think it's better without "specific" if we use the statement, I really do. These services include programs. Let's leave it out.

Now, however, some of us have a feeling that we don't need this at all. Are we better off without it? Bob, what would you do?

DR. RIDGWAY: Sam's point this morning I thought was a very valid one -- that we need to indicate that there is something different here. I think we need to spell it out more carefully here than we did in the first sentence to indicate that you don't add up a blind program and a deaf program to take care of it.

DR. MYKLEBUST: Yes, that has been very much stressed, and I would like this to come through for us.

Phil, you felt that all along?

DR. HATLEN: Yes. I think though this statement doesn't cover one area which I don't want to see left out, either, and that's the situations in which two services for singly-handicapped children can combine to serve a child.

I'm thinking of, for example, a mentally retarded visually handicapped child who is placed in one or the other program with an itinerant teacher serving him, and this works out quite satisfactorily in most cases, and I don't see the necessity for something different in that case.

DR. RIDGWAY: "Not necessarily."

DR. MYKLEBUST: Bob says to meet this we say "not necessarily." Does that help, Phil?

DR. HATLEN: All right.

DR. HEWETT: Can't we put that whole statement, "Special education services different from those required for children with a single handicap include programs and methodologies which are not the sum of approaches," and then kind of wind that up in some way? Because I think we have to be consistent if we are going to pull out from the main definition. In other words, we are going to have to take that whole phrase, aren't we, Corrine, out of there and then try to work it in?

"These services" is too abrupt.

DR. MYKLEBUST: That's right.

DR. HEWETT: That means we have to patch up the end of it somehow so it is not too redundant.

DR. HEWETT: Don't you really have "special education services different from those required for children with a single handicap" underlined?

DR. ASHCROFT: Say "different special educational services."

DR. RIDGWAY: We wouldn't have to use the exact phraseology.

DR. MYKLEBUST: Special education services include. All right?

DR. BLAIR: Well, I think the meaning --

DR. MYKLEBUST: It isn't what we were doing before. We were taking out-- You see, this should be somewhat consistent in format. Editorially it is desirable, of course. So why not just do it the simple way. Take "special education services."

DR. BLAIR: Refer to.

DR. HEWETT: We could say "in ways which require different education services" up in the main thing and then put the comparative down below.

DR. MYKLEBUST: I didn't follow that. I see now. We would have to take that whole last part, "special education services different from those required for children with a single handicap" include.

DR. KASS: Why couldn't we add part of this to the sentence which is not too long to begin with. Say "special education services which are not necessarily the sum of approaches commonly used."

DR. HEWETT: Different from and not necessarily --

DR. KASS: Different from and not necessarily the sum of approaches -- the sum of something -- required for children with a single handicap.

DR. CHALFANT: Then you are defining in a positive and a negative way in the same sentence. It's very easy to grasp that first sentence right now.

DR. MYKLEBUST: The first sentence is really worked out very, very well. It is really hammered out beautifully. It is possible that we could put some of it up there. But we already have a format precedent where we are doing this.

So we could just go ahead and put this "special education services different from those required for children with a single handicap." We'd have to repeat this.

DR. KASS: The whole thing.

DR. MYKLEBUST: Then "include." Wouldn't we?

DR. CHALFANT: I'm not sure if we would or not.

DR. MYKLEBUST: Where would you cut it, Jim?

DR. CHALFANT: Could you say, "By 'special education services which are different' we mean" -- or "is meant" -- this other idea? That way you wouldn't have to reproduce three-fourths of the original definition.

DR. MYKLEBUST: Well, otherwise I think we had the suggestion that "different special education services include."

DR. CHALFANT: Yes.

DR. BLAIR: I think that changes the meaning a bit.

DR. MYKLEBUST: Yes, it does.

DR. BLAIR: When you put "different" at that point.

DR. MYKLEBUST: Yes, it does.

DR. CHALFANT: Which are different.

DR. RIDGWAY: How much would we hurt the simplicity of the first sentence if right after "different from" we said "and not necessarily the sum of approaches used or approaches commonly used with children with separate or individual handicaps"?

DR. KASS: Required for children --

DR. HEWETT: You could add a sentence and say, "Such services are not necessarily the sum. . ." In other words, you can add it as a final sentence there. "Such services are not necessarily the sum of approaches commonly used with such children."

DR. MYKLEBUST: I think this is a real possibility. Any other reactions as you see it there? That simplifies it? Don't you think?

DR. RIDGWAY: Instead of "approaches," we can put "programs and methodologies" in up there and move right ahead.

DR. MYKLEBUST: Right.

DR. BLAIR: That may do it.

DR. MYKLEBUST: Do we have it all up there?

DR. KASS: I didn't catch that. Such services are not necessarily the --

DR. RIDGWAY: -- the sum of programs and methodologies commonly used. And start with "which." Knock out the rest of that. Knock out "which" also. And knock out "sum of approaches."

DR. HEWETT: Commonly used with these children. We have got our reference of children. Can't we just say "these children"?

DR. RIDGWAY: No, we don't have that part in there.

DR. HEWETT: Yes, we just said it -- required for children with a single handicap. Doesn't that take us back to children with a single handicap?

DR. RIDGWAY: You're right.

DR. MYKLEBUST: Yes.

DR. HEWETT: We can't say "such children."

"These services" might be better, and then "these services are not necessarily with such children."

DR. KASS: Commonly used in special education?

DR. MYKLEBUST: Commonly-- Frank is getting at this. Commonly used with children --

DR. HEWETT: I say "with such children," and put "these services" to start that sentence. "These services are not necessarily the sum of programs and methodologies commonly used with such children."

DR. BLAIR: I think that's not going to be clear enough, Frank. I think when you see it laid out there it won't -

MISS TAYLOR: It goes back to the multiply-handicapped.

DR. HEWETT: Singly-handicapped children.

DR. BLAIR: I think "such services" might be all right but I think --

DR. MYKLEBUST: Those having individual handicaps.

DR. HEWETT: That would do it.

DR. BLAIR: Yes.

DR. MYKLEBUST: Commonly used with those having individual handicaps. And then, Corrine, up there change "these" back to "such."

DR. HEWETT: "Such" is a better introduction.

DR. MYKLEBUST: Now, Sam Ashcroft has something. Sam, go ahead.

DR. ASHCROFT: It's only a general observation. I have been led to this every time we try to define a group. We are so educationally oriented we want to educate society and the profession and spell things out so that people can do them by cookbook recipes.

DR. MYKLEBUST: Yes.

DR. ASHCROFT: I don't think we should have to do that. Anyone who wants to provide services for multiple handicapped children shouldn't be in the business if he has to be instructed by a definition.

DR. MYKLEBUST: Well, I think this, however, is simply saying what we mean in the definition by "special education services." Now, that is the question again -- whether it is really necessary.

DR. BLAIR: I don't think --

DR. MYKLEBUST: There seem to be both opinions, and again I should think there is merit to both sides.

Yes, Frank?

DR. BLAIR: I was going to say it is partially a mandate, but I don't think it is a prescription, Sam, for precisely how this must be done.

DR. HATLEN: One other thing on this.

DR. MYKLEBUST: All right.

DR. HATLEN: As I understood it, when we were breaking this sentence apart, "special education services" up t that point -- and as this committee down here defined it -- referred to services as we know them in special education.

Now we are saying that such services-- The added sentence is now referring to such services that are different, isn't it?

DR. MYKLEBUST: Yes.

DR. HATLEN: So we can't use "such" necessarily, because that assumes we are referring back to the services in the previous sentence, which wasn't meant to indicate the services for multiply-handicapped.

DR. HEWETT: Such different services.

DR. MYKLEBUST: It's the different ones, though, Phil. Special education services different from those. So I think the "such" is a proper reference there.

DR. HEWETT: It takes us back to that whole phrase.

DR. MYKLEBUST: Yes.

DR. SELZNICK: Phil is suggesting it should be "such different services." I think that's what Phil is suggesting.

DR. HATLEN: Yes. But if we look at that in its entirety, it seems to go okay.

DR. MYKLEBUST: Yes.

DR. HATLEN: How about "single handicaps" instead of "individual"?

DR. MYKLEBUST: "Single" is better I think.

DR. CHALFANT: If I didn't know very much about the special education and I looked at this, I would say, "Well, what services are they talking about then?"

To me this sentence may very well raise questions in people's minds as they read it. I think it raises more questions than it solves.

DR. HEWETT: We have to define "special education."

DR. CHALFANT: That's what we are doing.

DR. HEWETT: We're getting down to the kind of primer level that Sam is mentioning here.

DR. MYKLEBUST: It seems to me, Jim, that it is highly desirable that we not suggest or indicate exactly how these are different. In the definition we are saying they are not the sum of those which exist. Now, actually, what we are doing as a conference is to suggest we need lots of innovation. Something has to be done. And, believe me, so far as I know, it isn't being done very much.

DR. CHALFANT: I'm not suggesting we try to spell it out.

DR. MYKLEBUST: I think this is what we mean by this additional statement.

DR. CHALFANT: The thing is a negative statement never helps me very much, and it always raises questions in my mind, and I am sure it will in others'.

I'm not suggesting that we go into any more detail. I just don't think it adds a great deal.

DR. DENO: Can I throw out a different statement and see if it does anything for Jim?

DR. MYKLEBUST: Go ahead, Evelyn.

DR. DENO: I have a positive statement which includes our three parameters. I wonder whether it did anything for you.

"Different special education services" may include standard service components organized to produce a unique impact, development of unusual services which -- well, I have got something redundant in here -- which may need to be developed to accommodate to the distinct effect on learning produced by the interaction of handicaps and staff trained to understand the educational implications of interacting handicaps.

It is those three components again, putting them positively.

MISS TAYLOR: May I ask a question?

DR. MYKLEBUST: Sure, Jo.

MISS TAYLOR: Who do we think is going to be reading this who won't understand what we mean by the first two paragraphs? And if we are thinking of legislators, haven't they already passed a great deal of legislation pertaining to special education and somehow must have gotten an idea of what it is about? It seems to me so condescending, sort of arrogant to be spelling this out to such a degree for people in the field. And people outside of the field must have some --

DR. MYKLEBUST: And still as a committee here we have a very hard time saying it, a very difficult time.

DR. HEWETT: But there is I think a very desirable sort of presentation of the need for innovation and some kind of unique putting together of programs that is implied by that last statement. It is sort of a challenge to the field: "Look, just don't think 'different' means 'sum total.'"

DR. MYKLEBUST: That's right.

DR. HEWETT: It's the "you've got to pick the ball up and do something" kind of thing.

DR. MYKLEBUST: This is precisely the way I feel about it.

DR. HEWETT: It has a nice ring to it.

DR. MYKLEBUST: I really can't assume that teachers or groups or training centers-- I think as a committee we are not being arrogant. I think we are being realistic if we assume that some challenge in this area would be helpful. I really do.

DR. HEWETT: Because, you see, there really isn't any precedent. We're not referring to a body of knowledge or programming that is there. It has got to be developed in a sense. We are just saying, "Go out and do something about it."

DR. MYKLEBUST: I think that's one of the great virtues of the statement.

Jim?

DR. CHALFANT: Isn't the challenge in the phrase "different from those required for children"?

DR. MYKLEBUST: Yes, but you spell it out so you tell a little bit more about what you mean by the challenge. Different alone doesn't do it for me. I think there is a lot left out in "special education services different from."

What you have added here means a great deal more to me. Not necessarily the sum of the programs, and so on.

We had that in, you know, this morning many different ways. We don't just add this up and get a multiply-handicapped program or services which are adequate to the multiply-handicapped child.

DR. BLAIR: Just one matter of refinement, and that is whether we have in terms of paragraphing here put description of the services a little bit out of place.

Looking at our previous definition of yesterday, we define things as they occurred in the definition. And, you see, "combinations of handicaps" comes first and then "services."

For convenience we have brought "services" in right following it in the original definition, which I think is perhaps the more important of the considerations here. But I'm just wondering in terms of polishing whether we need to --

DR. HEWETT: We could put in parentheses after "combination of handicaps" that definition of two or more of the following with the colon.

DR. MYKLEBUST: You could.

DR. DENO: Put "combinations of handicaps" and then followed by "such."

DR. MYKLEBUST: I like the way --

DR. BLAIR: I think it's in there, but I'm just talking about --

DR. MYKLEBUST: I think we've got it. You see, you put parentheses-- Where was that, Frank?

DR. HEWETT: It might make it unwieldy, but after "combinations of handicaps" put in the definition.

DR. MYKLEBUST: That's the idea.

DR. HEWETT: Then we keep our --

DR. MYKLEBUST: Two or more of the following. We don't need "'combinations of handicaps' denotes." That's it.

DR. WOLFE: What in the world did you do? I can't get there from here.

DR. HELLER: Read it now.

DR. KASS: "'Multiple handicap' refers to combinations of handicaps (two or more of the following: emotional disturbance, learning disability, mental retardation, sensory or motor impairment) which interact to impede development and learning in ways which require special education services different from those required for children with a single handicap. Such services are not necessarily the sum of programs and methodologies commonly used with those having single handicaps."

DR. DENO: You can make it more challenging and go on and say they call for innovation, and so on.

DR. HEWETT: Say "charge" -- with an exclamation point. (Laughter)

DR. MYKLEBUST: Ladies and gentlemen, I think that is a good statement. I think this is a very fine statement. And we are up to two-thirty. I would like to sort of terminate the discussion of this problem of multiple involvement.

I think the area of multiple handicap here certainly from my point of view has been substantially clarified. And I thought perhaps for just a few minutes before you want to leave that we would have time to ask each other whatever few questions we want to, perhaps as some of these things might apply to us in our own programs.

Is there anything we want to ask? Does anyone have-- Yes, Bill?

DR. HELLER: I have a question.

DR. MYKLEBUST: Go ahead.

DR. HELLER: I suppose I could ask Corrine some day at the office. But as an outsider in the field of learning disability, how do you envision programs for these children being set up in special classes and the number in classes and how these will be staffed?

Because I think when we think of a training program it isn't so much the individual program but how they are going to be grouped to handle them. And I just wonder how this is going to be done.

DR. MYKLEBUST: Well, in our own efforts, Bill, we take learning disabilities on a continuum.

Now, as a general rule of thumb, we can say that the receptive auditory involvement is the one that is the most debilitating and the one that you see first. That is, you see them in the younger children, preschool, early school life. Because receptive auditory dysfunctions impede all "getting along in school" kind of learning, you see.

DR. HELLER: Right.

DR. MYKLEBUST: So you see these early in life.

Incidentally, I saw all of the children with Strauss in his school two or three years, worked closely with him on these, and I feel now that what he described was mostly the auditory involvement children in terms of newer pathology. By the way, our neuropathologist would say it is the temporal lobe case. Because they are the ones where you get this great distractability and debilitation of behavior, Bill.

So along with this auditory you get this breakdown in behavior in early life -- that is, early school life and before.

Now, you can't put those in big classes. Here's a population you have to handle down to six in a group, and so on.

We have experimented, by the way, with three, four, five, six, and so on, different degrees and ages, and they are by far the most difficult to group.

The moment you get away from this population and talk about those with dyslexia, you can group them in large classes. They are easy to manage -- typically now. There are exceptions always.

A certain segment of dyslectics are not that easy to handle. But typically dyslectics as a group can be classified into classes of ten, 12, 14, not more preferably, but you can do good-sized classes with them if you have the proper instructional program and trained personnel.

We also make this assumption: That many of these youngsters particularly with reading and spelling disorders can be handled on an itinerant basis. Not special classes.

I would suggest that possibly eventually the big percentage of your learning disability children should be handled through regular classrooms with help through regular teachers. This is my opinion on this and the way it tends to work out very well time after time in these children.

You classify them in a certain way and you find this group has different needs in terms of classification than this group, and so on.

Does that answer it at all? Do you see what I mean?

DR. HELLER: Yes. Well, as we have gone around the country this summer in regions and all, we have run into quite a few programs that have been on the itinerant basis. They have selected a teacher from an elementary classroom and sent her back for some training, and then she has become an itinerant specialist in learning disabilities.

DR. MYKLEBUST: Right.

DR. HELLER: I was just wondering how common this is.

DR. MYKLEBUST: It's going to be that way I think for a long time. For one reason it serves more children, and the personnel is extremely limited.

DR. RIDGWAY: Another pattern is the center where youngsters are taken perhaps from the building in which they are located, sent to another building in the district for evaluation and some diagnostic teaching, until you find out exactly how to treat the youngster, and so some of the people who are being trained in this field teach classes where the youngsters are itinerant in a way.

They come in and are there perhaps for four weeks, perhaps six months. As soon as you get them moving, then you try to get them back into regular classrooms.

DR. SELZNICK: I think in the long run though they are going to have to look at services for children with learning disabilities on a continuum, because they are not a single entity. And the kind of service and the frequency of service will vary with different groups of youngsters. And so the itinerant service is going to be adequate for part of this population, but others are going to require-- And some will benefit by going to a center, but there are others who will find it necessary to spend the major portion of their schoolday in a special environment and gradually be reintroduced into the other stream. In other words, a continuum of services for this segment.

MISS TAYLOR: Having sort of a resource room idea for varying lengths of time according to the child.

DR. MYKLEBUST: This is used too.

Yes, Bill?

DR. WOLFE: We have been doing some predicting in the last couple of days. How in the world are we going to handle the MBI classes?

DR. MYKLEBUST: Minimally brain-injured?

DR. WOLFE: I don't know whether I mentioned this to the group or not. In our State we have such classification, and it's under the physically handicapped. And it is posing major problems for us.

DR. MYKLEBUST: Like what, Bill?

DR. WOLFE: The certification bit. All that is required now is the same courses for the teacher of the physically handicapped, cerebral palsy and the whole bit.

DR. MYKLEBUST: I see.

DR. WOLFE: I personally feel and members of our staf feel that these are two very different areas. They are more in the areas of learning disabilities as I understand it.

Also, our people do not understand what the word "minimal" means. They think the brain is a little bit injured. It's not that at all. It's symptomatology --

DR. MYKLEBUST: That's right.

DR. WOLFE: -- that is involved. What is happening nationally? Is this something that is in every State, this MBI program, or what?

DR. BLAIR: It varies with States tremendously.

DR. WOLFE: How do we cope with this?

DR. BLAIR: Wisconsin is using "special learning disability." "Hyperkinetic" in Missouri.

Possibly one of the fruits of our endeavors here hopefully -- although I don't know you can change these things once they are on the books -- would be at least to begin to reconcile some of these differences. I don't know now if it is too late in some cases.

DR. WOLFE: It would seem to me the MBI should be broken down, and those with brain damage which would cause them to be cerebral palsied and obviously physically involved should go that way. The others should be put in the learning disability group and forget the MBI label.

DR. MYKLEBUST: Yes. I couldn't agree more.

DR. MYKLEBUST: This is the direction that your effor would be most worthwhile. I really must agree entirely.

I don't want to take time from the question of discussion to review, but just to mention the term "minimal" has been discussed by the hours, has been thrown out. "Brain-injured" has been discussed by the hours, and it is not really apropos for most of them.

DR. WOLFE: No.

DR. MYKLEBUST: Well, I couldn't agree more. I think if you go in the direction I thought you were suggesting yesterday in Texas that you were going towards learning disabilities, it would seem to me it would greatly solve this. I thought you were going to say with this designation you can't put him in a class unless a neurologist finds him. See? This is happening all over. You're getting into terminology which is not educational. So the educator's hands are bound until somebody says, "Well, look, you can have him."

DR. WOLFE: Right.

DR. MYKLEBUST: See?

DR. WOLFE: Right.

DR. MYKLEBUST: Now, this we are trying to help with certainly in a great many different ways, because most neurologists don't want this today. Please look at the last issue of NEUROLOGY in which there is a whole page there, combination of Council of Pediatrics and Neurology.

Now, the point is that most of these people don't want to be in the position of saying, "Look, you have got to put him in this class." They don't know anything about this educationally.

DR. WOLFE: That's right.

DR. MYKLEBUST: But we are putting the terminology in such a manner that they are forced by regulation, if not law, that they have to do it.

DR. WOLFE: That's right.

DR. MYKLEBUST: So I think it is unfortunate that terminology has gone so far and will cause difficulties for some time until we have some kind of retroactive effect.

DR. WOLFE: Finally, Mike, I would like to clarify your interpretation of what I said the other night at the dinner. And you interpreted what I said I think to mean that I did not recognize the existence of a language disorder. This is not correct.

I said I didn't fully understand what was meant by this.

I feel -- I'm putting myself back in Texas -- I feel that if we had gone the language disorder route in our legislation this would have been a very narrow concept. We want to include the language-disordered child but under specific learning disabilities.

DR. MYKLEBUST: No, I knew you meant that. It was Frank who was taking issue with it.

DR. WOLFE: Excuse me.

DR. MYKLEBUST: I knew it, and when I was in Texas I specifically tried to recommend to Dr. Barron and his committee that they not call it "language disorders," Bill.

DR. WOLFE: Everybody has recommended that to Dr. Barron.

DR. MYKLEBUST: Of course, it didn't work. They went that route anyway.

DR. WOLFE: Yes.

DR. MYKLEBUST: That's what it was turned down on.

DR. WOLFE: Right.

DR. MYKLEBUST: I think there if you got learning disabilities it would have resolved some of this, don't you think?

DR. WOLFE: Indeed so.

DR. DENO: I think we could get some help from the U.S. Office of Education leadership. I was in there once on a State Directors' meeting having to do with Title VI, and we were talking about the different classifications in Title VI and the means of their identification.

Some of us were working pretty hard to try to be sure that learning disabilities did not require neurological certification for the child to be eligible for service.

DR. MYKLEBUST: That's right.

DR. DENO: But it seemed the U.S. Office of Education was a little reluctant to let go of the safety guard at that point.

DR. KASS: Yes, we had some of the history of this yesterday when Dr. Kirk went through his testimony and the misinterpretation of it in the Senate Report. And this is what the Office of Education used for the Title VI discussion.

DR. BLAIR: I will have to ask Corrine whether she feels that our definition of learning disabilities is less a can of worms than it was yesterday.

DR. KASS: Well, I never thought it was that to begin with.

DR. BLAIR: I know you didn't.

DR. KASS: I think you have several fine definitions and several fine programs. I am very happy, however, with this definition, and I am happy to have the backing of a group of professional people, as I am sure you are too.

DR. MYKLEBUST: Yes. I would like to try to explain a little bit more that-- I don't know why I didn't use this term before. You reminded me. But our conference is made possible under the rubric in the U.S. Office Bulletin: "institute for advanced study." So we have been members of an "institute for advanced study." That is the way this is done. And, believe me, for me it has been an institute of advanced study. I mean you have helped me a great deal.

DR. DENO: This is why we have such a hard time defining up there. That's such elementary stuff we think anybody ought to know it. We're too advanced to try to define that. (Laughter)

DR. SELZNICK: Are you ready for some comments?

DR. MYKLEBUST: Oh, yes. Ready right now. Go ahead.

DR. SELZNICK: I was going to explain what I meant by that emotionally charged-- Where I am concerned, the word "innovation" is emotionally charged like "Rafferty" in California and some other terms, because I think it has come to mean many things to many people.

But, anyway, the comment I really want to make is I don't know who brought this particular group together, whether it was Mike or Corrine or who, but I don't know that I have ever been in a group where a group of people from different orientations, many of whom didn't know one another prior to coming together, were able to communicate and to come to basic agreements and to work as effectively with one another in my long years in special education.

I think it's a compliment to the people that brought them together and also to the other persons who are here that they were able to relate so readily and easily to one another.

DR. MYKLEBUST: Thank you very much for your comment, Harry. I appreciate it very much.

DR. WOLFE: We could have come together as this same group, and without the kind of chairman we had we could have sat here and looked at each other and gotten nothing done -- seriously -- because you are a driver, man. I can tell you. (Laughter)

Two more days of this, and I could resent you. (Laughter)

You go, go, go. I mean it's good, but two days and a half would be enough.

DR. MYKLEBUST: You're wonderful.

DR. BLAIR: I wish some of our faculty committees would do as well.

DR. WOLFE: Indeed.

DR. MYKLEBUST: Well, thank you very much, all of you, for coming. It has been a great pleasure to work with you, to learn to know you.

I do want to express appreciation to every one of you and then to say that without Corrine's help all the way we couldn't possibly have done this advanced study institute. She has been most helpful and pushing with us all the time in order to hold it and to accomplish it this summer.

I don't think she will mind if I explain a little bit that funds were very limited for this purpose. We agreed that we needed Mr. McLaughlin, that to keep this going we needed it transcribed. Now, you all know that you will receive a copy of this transcript just as soon as it is available. There is going to be a lot of verbiage. But there is excellent, beautiful discussion in this. I hope you will look at it very carefully.

I'm going to ask Corrine to help me to explore further any editing process, and so on, that might make it better. But you will all have to agree to whatever is done.

Now, the cost of having Mr. McLaughlin here -- he is an expensive guy, you see -- is such that we didn't have much money left for you people, as you well know. I'm explaining why we couldn't go the usual route for your honorarium. It just wasn't possible -- not that and have transcripts. So we took the route of transcript, which I hope in the long run is going to be of great benefit, if not monetary, to you.

Now, with that, again I say I greatly appreciate the time and effort that you have given to this study, and I expect that we will be in touch with you pretty soon, as I think Mr. McLaughlin has assured us that the transcript will be available to us quite soon -- not tomorrow, but fairly soon.

We have only one copy for each of you, by the way, in the estimate of costs involved. We have only one copy for each of you. That will be your copy to keep, to use for all further reference in terms of what will be done with the material produced here.

Now, I should think then that early this fall we'll be ready to explore with you by letter how you are coming with it, wha you think about it, and I think by then perhaps

I could have a chance to go over this with Corrine further and we would know something more about what we could suggest.

Remember we said before that we will need help in lists of organizations or at least the heads of organizations that should be included, because we're going to have to work out a way to get more copies than we have ordered now.

But it seems to me that it might mean copies after editing, to reduce expense, and so on. The ones we have now will just be once around, one for each. That's all we have.

Again, thank you very much. I look forward to seeing you all again soon.

(Whereupon, at 2:45 p.m., the Conference was adjourned.)

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